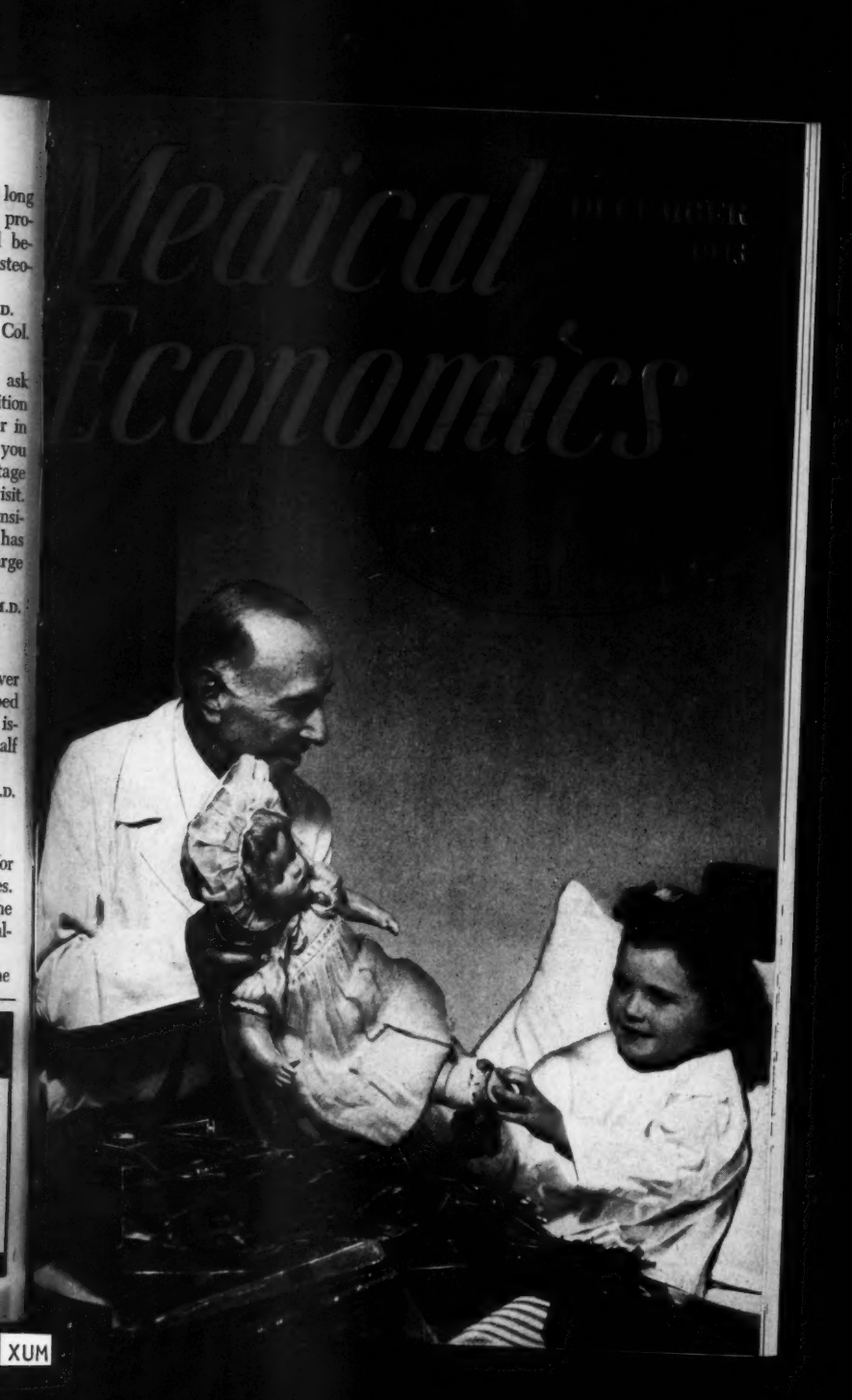
Medical Economics

NATURE provided the Clues . . .

FOR THIS NEW PROTECTED VITAMIN A PREPARATION

Nature protects virtually *all* natural foods with skins, rinds, pods or shells. Once this protective covering is removed the vitamin content may be quickly inactivated.

The human body apparently receives most of its vitamin A in the form of carotene (provitamin A)—to produce the *one or more* types of vitamin A required for normal functioning.

With these significant factors in mind, S.M.A. Corporation has evolved a new, *fully* effective vitamin A preparation—Caritol, SMACO:

● *The only preparation protecting the vitamin potency of both vitamin A and carotene with mixed tocopherols.*

Caritol Capsules SMACO, bottles of 100 (25,000 U.S.P. Units Vitamin A Activity)

Caritol with Vitamin D Capsules SMACO, bottles of 100 (5,000 U.S.P. Units Vita A Activity; 1,000 U.S.P. Units Vitamin

Caritol with Vitamin D Liquid SMAC bottles of 10 cc. (15,000 U.S.P. U Vitamin A Activity; 3,000 U.S.P. U Vitamin D per gram)

Caritol with Vitamin D Liquid SMAC bottles of 50 cc. (15,000 U.S.P. u vitamin A activity; 3,000 U.S.P. u vitamin D per gram)

Caritol Liquid SMACO, bottles of 50 (15,000 U.S.P. units vitamin A activ per gram).

Literature and trial quantities up request. A SMACO nutritional l chemical.

CARITOL

SMACO

TRADEMARK REG. U. S. PAT. OFF.

S. M. A. CORPORATION, DIVISION WYETH INCORPORATED

Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

DECEMBER 1943

Cover photograph by Ewing Krainin

CIRCULATION 110,000

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Acting as a continuous warm, moist dressing, Numotizine simplifies the once difficult problem of "exheat" throughout the night.

In the treatment of local inflammations — furunculoses, sprains, tonsillitis, chest conditions—the analgesic and decongestive actions of Numotizine are accomplished without the time-consuming necessity of having to heat and replace dressings at frequent intervals.

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Speaking Frankly

Abstracter

I employ a system similar to that described n your article, "Index as You Read!"—but with one major difference:

In my opinion any article worth saving is worth abstracting. Consequently, useful articles are abstracted on 5" x 8" cards and filed by subject, with cross references properly indicated. Statistical tables, graphs, etc. are pasted on the 5" x 8" cards and filed likewise. Culled journals are then thrown away.

M.D., Colorado

Shortage Exaggerated

In the last year there has been so much ill-advised talk in the press and over the radio about how overworked physicians are that the physicians themselves are beginning to believe they must invent all manner of revolutionary devices in order to continue to practice medicine.

This is probably true in crowded defense centers, bu I do not believe it holds true for the country in general. Admittedly, many physicians have gone to war; but it is also a fact that many millions of patients have gone to war too and have moved from their homes to war centers.

Few physicians seem to realize that immediately after the war the services may demobilize about 40,000 doctors. These, combined with new graduates resulting from the accelerated courses and the substantial influx of foreign doctors, will result in a situation where many medical men—as well as their patients—will be ready for relief.

My advice is to take the call and collect a fee commensurate with the times. Money is free now and must be saved against the inevitable leaner day. Money invested in war bonds and in real estate in a good location at a purchase price that will return a fair interest at the low postwar rental is the physician's best assurance of self-sufficiency when the present prosperity collapses.

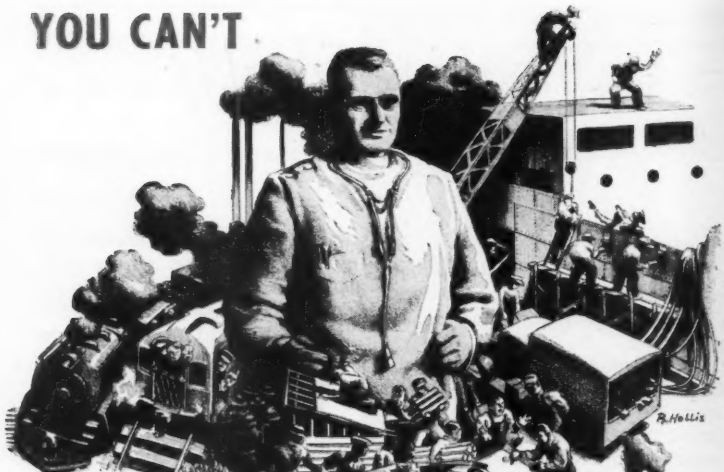
M.D., Delaware

Lanham Act

The purpose of the Lanham Act —to provide federal financial aid for the wartime construction of hospitals—appears progressive, judging from your October article. If well administered the program should confer lasting benefits upon many American communities. However, a number of the hospitals will be of temporary character, designed to relieve only a wartime strain. Wouldn't it be more economical in the long run for the WPB to permit permanent construction? Then the communities might be more inclined to undertake their share of the costs. Otherwise the program may become just another strain on the government's already overworked pocketbook.

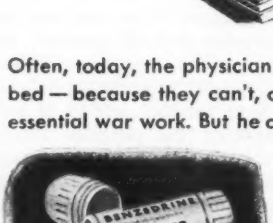
I feel, too, that the administra-

YOU CAN'T



...BECAUSE THEY CAN'T

Often, today, the physician can't get his head-cold patients to go to bed — because they can't, or feel they can't, absent themselves from essential war work. But he *can* do much to help these patients. He can give them marked comfort and relief by prescribing BENZEDRINE INHALER.



A volatile vasoconstrictor. Each tube is packed with racemic amphetamine, 250 mg.; oil of lavender, 75 mg.; menthol, 12.5 mg. Benzedrine is S.K.F.'s trademark, Reg. U. S. Pat. Off.

Benzedrine Inhaler is so outstandingly convenient that the physician may overlook the fact that it is, first and foremost, a highly effective therapeutic agent.

BENZEDRINE INHALER

In a Modern Plastic Tube

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

tion might well appoint an advisory committee of representative physicians, both civilian and military. They could put a curb on some of the excessive spending that is so fashionable nowadays.

M.D., Michigan

I am of the opinion that private capital, local or otherwise, should finance the construction of hospitals wherever possible. There is plenty of cash available for investment in reasonably sound ventures. In our town, we had no difficulty in obtaining private capital at 6 per cent for the building of a wing to our private hospital. We could even have obtained it from an insurance company in another town at 5 per cent.

M.D., Texas

The Lanham Act may sound like an emergency measure, free of the clutches of the U.S. Public Health Service, but I don't feel the PHS will continue to keep a hands-off policy after the war.

M.D., New York

Isn't it possible that local communities (which seem to have been cool about paying a share of construction costs) may know more about their hospitalization needs than a hastily formed Washington bureau? Is it not possible that a considerable percentage of the applications for federal funds have come from that stratum of political society which for the past ten years has been perfectly willing to grab blithely all the federal money placed within reach?

Asa E. Seeds, M.D.
Dallas, Texas

I'm "agin" it. Add this federal subsidy to the activities of the Blue Cross, and we'll all have to get salaried jobs in hospitals or turn in our licenses.

M.D., Texas

Ulterior Motives

Here is what I recently wrote to a New York life insurance company:

"I am enclosing a check in payment of my policy. However, I wish to protest against the decision of your company and a few others to discontinue the mailing of reminder notices a few days before the expiration of grace periods. This will result in the lapsing of many policies held by those who, for financial reasons, have taken advantage of the grace period.

"Anybody with even minor knowledge of office routine cannot accept the explanation that the manpower shortage forces the elimination of this notice. It is obvious that the follow-up of the lapsed policies entails more work, explanation, re-examination—and disappointment.

"It might be natural for many a person to assume that the real reason for the elimination of the notice is to encourage policy lapsing for whatever ulterior motives the companies might have.

"The whole business is not worthy of the good name of our life insurance companies."

Paul Lahvis, M.D.
Gowanda, N.Y.

Nuthouse

I do not ordinarily charge for suggestions given over the phone to patients who have minor maladies. However, I do make one exception to this:

There are certain neurasthenic, hysterical, or otherwise smitten female patients who call continually to receive psychotherapy over the

telephone, who take up a great deal of time, and—what is more important—who require an expenditure of energy and a suppression of emotion on the part of the physician that is considerable. To these, I make a sufficiently large charge to discourage their continuance as telephone addicts and to keep me out of the nuthouse.

Reginald D. Weiler, M.D.
Pueblo, Col.

"Nothing Wrong!"

I concur fully with your article, "There's Nothing Wrong With You!" The biggest mistake a doctor can make is to scorn the patient who brings in a vague complaint about "not feeling so good." I recall that in the last war Army doctors were inclined to ignore soldiers who came to them with all sorts of pains. I remember one case in which the answer to a complaint about a sore neck was, "Go wash it!" In another instance a soldier was dismissed abruptly when he complained about a bellyache. Next day he was undergoing an appendectomy.

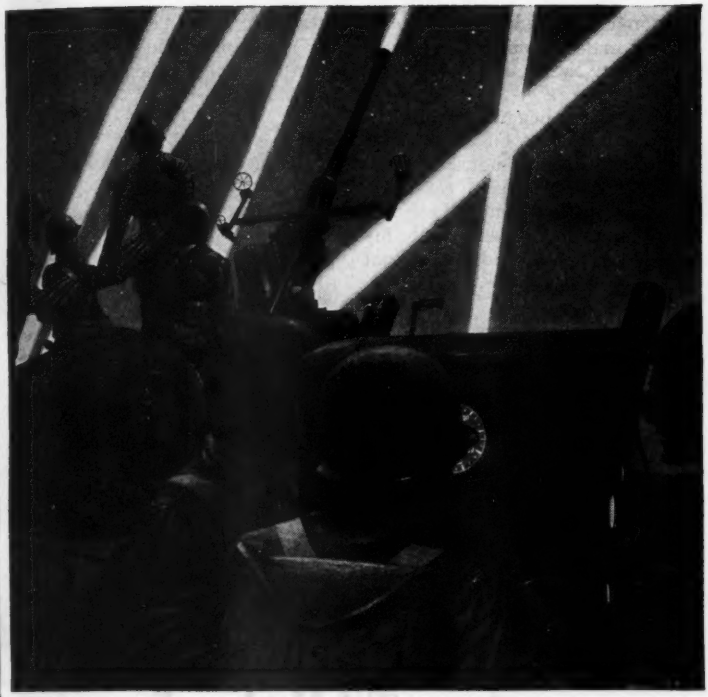
M.D., New Jersey

Collections

I have already put to the test one of the letters included in C. R. Sweney's October article, "Don't Neglect Your Collections," and find that it gets results. I've asked my secretary to start using the entire series.

M.D., North Carolina

I have a better system. As far as I'm concerned there are only two classes of patients: those who can pay and those who can't. If the first do not pay they get no service



The best shot in the world would be helpless without it!

Imagine trying to aim a huge gun at a tiny dot miles up and traveling across the sky at 300 miles an hour!

In many cases, it would be well-nigh impossible if it weren't for an electrical brain that actually makes lightning calculations and aims the gun automatically.

All the gunners do is keep two sights centered on the plane . . . one for elevation . . . the other for direction. The electric brain does the rest.

It is vitally important at all times to know the exact condition of the system that operates the electric brain . . . and that's the job of electrical indicating instruments.

Today Gruen is proud to be making precision instruments of this type for all services . . . proud to turn our 69 years' experience with *Precision* watches to this new and vital job.

Please remember this . . . when your Gruen dealer has to say, "Sorry, but we no longer have the particular model you want." The Gruen Watch Company, Time Hill, Cincinnati, Ohio, U. S. A. In Canada: Toronto, Ontario.

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THE PRECISION WATCH

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AMERICA'S CHOICE SINCE 1874

from me. The indigent are taken care of under a contract our medical society has with the county supervisors.

I once tried begging and threatening to get what I'd earned, and I know how that handicaps a professional man. I much prefer to have my patients come to me and say, "I thought I'd better settle my account. When I need you I want to be sure you'll come."

M.D., Iowa

Sweney's plan seems to be the best I have yet come across.

M.D., Illinois

Strong Man Needed

What medical men need is a manager—a man like John L. Lewis, Philip Murray, or Mac Cahal, secretary for the radiologists. Doctors can accomplish little for themselves, even to keeping peace in their own ranks.

M.D., California

Relocation

One state licensing board I know of isn't assisting in the relocation of physicians in shortage areas—it's blocking the program. I was licensed in that state about ten years ago but have since been practicing elsewhere. When I offered to return, to help relieve the physician shortage, I was told that my license had been cancelled because I'd failed to pay the annual fee which is required whether the licensee practices in the state or not. Furthermore I was told that I'd have to appear before the board, state where I'd been and what I'd been

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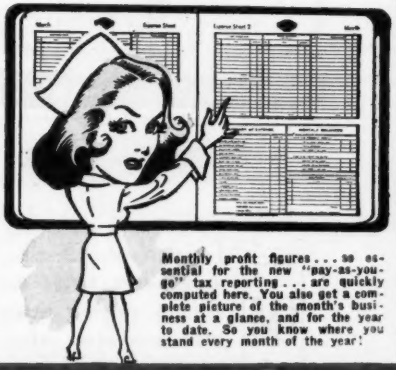
Just a few minutes a day and the job's done with the Daily Log! And it's ideal for pay-as-you-go tax reporting. Your own assistant can do the reporting for you *easily* if the Daily Log is used... and no special bookkeeping training is needed.

Notice, too, that the Daily Log specifically fits your needs. That's because it was originated by a doctor who understands a doctor's problems.

This explains why thousands of doctors are now using the Daily Log year after year... and swear by it! So the Daily Log can probably help you, too. Notice these features:

Each day, the names of patients, services rendered, and charge, cash, received-on-account items are entered on a simple, neat page like this. Likewise, daily expense items are entered on monthly forms. Daily totals are quickly carried forward to the monthly Business Summary.



Monthly profit figures... so essential for the new "pay-as-you-go" tax reporting... are quickly computed here. You also get a complete picture of the month's business at a glance, and for the year to date. So you know where you stand every month of the year.

And with the Annual Summary, your assistant can practically make out your final income tax report alone—and no accounting experience is needed. Did you ever see a record book that was so simple, and yet so thorough? And each year you will have a permanent record that may prove invaluable later.

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. . . for PHYSICIANS

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doing in the last ten years, and explain why I had failed to keep up my license renewals. Then, it appeared, the licensing board would "take whatever action it sees fit."

M.D., South Carolina

Over 38

I understand that a directive was issued recently giving draft boards authority to induct physicians between 38 and 45 into the armed forces. I was under the impression that this could not be done except by a change in the draft laws and that an order which singles out any particular profession is illegal. Just what is the status of physicians in this age group?

M.D., Ohio

Our Washington correspondent reports that "The draft status of physicians between the ages of 38 and 45 is the same as that of all other men in this age group. No one over 38 is now being inducted into the armed services."

Fee Too Low

My state (Oklahoma) is participating in the Children's Bureau program to finance maternity aid for the wives of service men. The fee for delivery has been set at $35, without any adjustment for such special service as a Caesarean section. Ordinarily we charge $50 for a normal delivery. I do not particularly object to a smaller fee for the wives of service men but to set it arbitrarily at $35, without possibility of adjustment, seems unfair. The fees for infant care also appear far too small. I furnish my own drugs, for instance, and there is no provision in the program for that.

As far as I know, none of our

han Gonorrhea[1]

In the last two decades Trichomonas Vaginalis has been recognized as the most prevalent of the gynecological infections. Incidence has been averaged at between 25 and 30 per cent.

VIOFORM INSERTS* (iodochlorhydroxyquinoline with boric acid and lactic acid) are offered to physicians as a time-saving, effective and economical means for combating this parasite. VIOFORM acts to eradicate trichomonas vaginalis, while other included medicaments quickly restore the acidity of the vaginal vault. Each Insert contains 250 mg. of VIOFORM, 25 mg. of lactic acid, and 100 mg. of boric acid.

VIOFORM INSERTS may be given to patients for home use, necessitating fewer office calls in these war-rushed times. In mild cases one course of ten days is recommended More severe infections usually respond to two or three courses.

Write for literature

Am. Jl. Surg., 33:523,1936
Trade-Mark Reg. U. S. Pat. Off.

CIBA *Pharmaceutical Products, Inc.*
SUMMIT, NEW JERSEY

local doctors is participating. I signed up for two cases. One of them went through but I never heard anything more about the second application.

M.D., Oklahoma

Physical Waiver

If a physician signs a physical-defect waiver in applying for a commission in the armed forces, and is rejected, does the waiver have any effect on his draft status?

M.D., New York

Signing a waiver for a physical defect is a purely voluntary action and one usually taken by men who are applying for commissions in the armed forces. It does not in any way affect a registrant's draft status. An applicant for a commission who is rejected because of physical disability may be accepted and inducted by his draft board whether or not he has previously signed a a waiver for that disability.

Blue Cross

What arrangements does the Blue Cross make when, because of overcrowded conditions, it cannot get a member accommodations in a hospital?

M.D., Florida

C. Rufus Rorem, director of the Blue Cross, replies: "The number of instances is limited . . . The exact procedures are not identical with each Blue Cross plan. But when patients cannot be hospitalized, the contract provides, (a) refund of one or two year's premiums if hospitalization cannot be obtained in a member or non-member hospital; or (b) payment of a per diem allowance during a period in which the subscriber receives care in his own home or in a non-member sanitar-

ium, nursing home, or maternity home."

Maternity Aid

You state that more and more physicians are bitterly criticizing [the Children's Bureau program of obstetric and pediatric aid for the wives of service men]. Have you evidence that the individual physicians throughout the country are criticizing the program? We also have read of the resolutions of some of the medical societies, but reports from the states would indicate that these resolutions do not necessarily represent the opinion of the many thousands of general practitioners who provide most of the maternity and pediatric care in this country . . . You state that osteopaths, chiropractors, midwives, and cultists still are eligible to practice obstetrics in many states. It might be well to make it clear that these individuals have been legally permitted to practice for many years . . . I do not know of any states in which chiropractors or midwives are participating . . . A few states have indicated that osteopaths have the same rights under law to practice obstetrics and may be permitted to participate.

Edwin F. Daily, M.D.
Children's Bureau,
Washington, D.C.

Phone Extension

The physician who complained, some months ago in your columns, that he was unable to obtain a badly needed extension to his telephone because of a WPB restriction, may be interested to know that this restriction has been modified in favor of physicians who need such extensions. It is only necessary

● Purchase of fine equipment is an investment—in ability to do better work and more work. The Ritter equipment pictured above, for example, places at his fingertips everything the ear-nose-and-throat man needs for examination and operation. saves his time and effort, increases his opportunity for specialized service and greater income.

Ritter Company, Inc., Ritter Park, Rochester, N. Y.

ARMY E NAVY

For Advanced Equipment-Look to **Ritter**

to make application to the phone company.

M.D., New York

South Seas Summary

After more than a year in the South Seas as an Army medico I appreciate more than ever one great virtue about service practice: You can do what's good for the patient, and not just what he wants. When you say, "Remain in bed," he stays there, whether he likes it or not. It's an order, and it won't be ignored by a temperamental prima donna. (Excepting, of course, the officer patients. Lord keep me from being in charge of an officers' ward!)

We are in a "fixed" hospital—at least so far as any installations can be fixed in these days of mobile warfare. Hospitals are established where they are needed, and not where comfortable structures can be found. If there is enough roofage on the spot, all personnel live in buildings. If not quite enough, the enlisted detachment sleeps under canvas. Sometimes medical officers and enlisted men are housed in tents, while patients and nurses live in buildings. Occasionally there's only enough roofage for a ward or two, and all personnel live under canvas, while patients overflow into the large, twenty-four-cot, wooden-floored ward tents.

Daily life is pleasant enough when compared with that of medical officers at more advanced field posts. To be sure we have no hot water for bathing or shaving, but at least we have showers. Ants crawl into nose and ears, but at least we have netting. We can't get candy, cigars, or a coke; but if lack of them will win the war it's as good as won.

[*Continued on page* 166]

Sidelights

A patient-load study completed recently by the U.S. Public Health Service (reported in this issue) proves once more that doctors are people. When choosing a locality in which to practice, they are guided by the same motives as any good businessman: they usually go where opportunities are financially, educationally, and socially good—which often means to a city rather than to a rural district.

And why not? Few hillbillies will beat a path through the woods to reach the door of either a better mousetrap-builder or a better diagnostician. Nor will they buy shoes or medical services (even though they need both) until they have first been educated to the use of such essentials. Let none assume, then, that without reasonable incentive doctors will hie themselves off to the deep, doctorless hinterlands to hang out shingles which only the birds will ever see. No businessman would do it. Is the physician any less human?

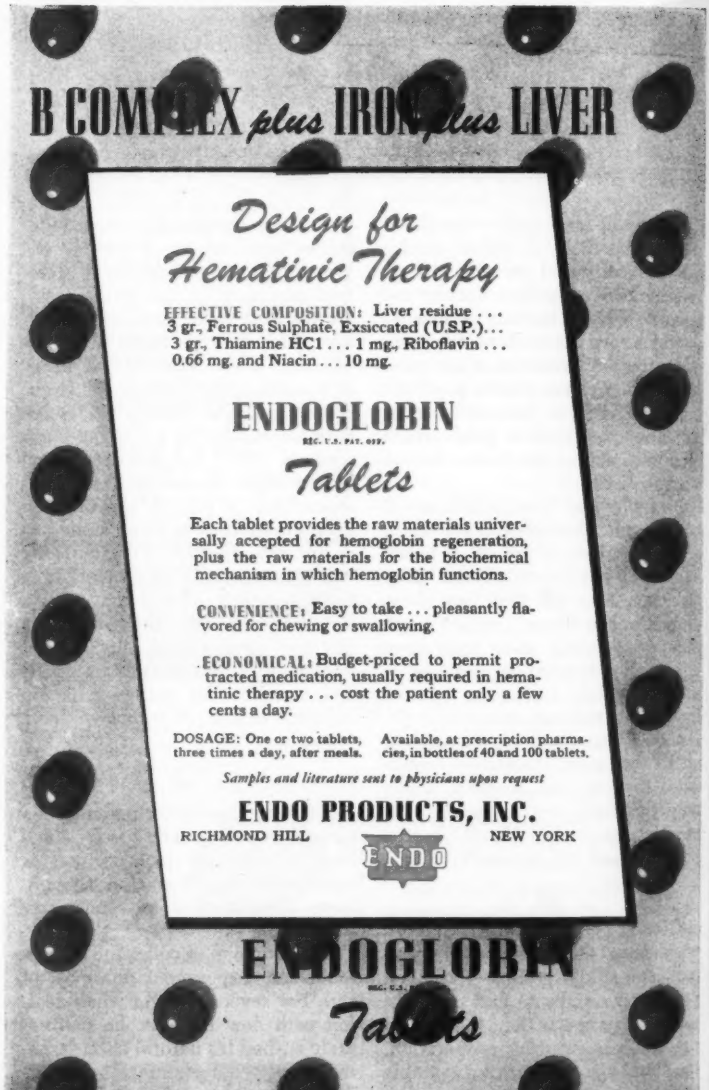
Getting good instructors has always been the bugaboo of postgraduate study groups. The first problem is usually to find the right man to give instruction; the second problem is to enlist his cooperation; the third involves making suitable financial arrangements. Still other complications follow.

At least temporarily, these difficulties have been swept aside by the War-time Graduate Medical Meetings described in this issue. Here, for the first time, is an *organized, national* effort to make the best teaching talent available at every crossroads in the country. By twenty-four regional committees and a national faculty of 1,200 top-flight medical men representing some twenty-eight specialties and subspecialties, a job of monumental proportions is now being done.

But the question is: How long will it continue? This is another of those blessings of war that should be continued *after* the war. As a key to better medical education of doctors—and, hence, to better medical care for the public—it is too valuable to lose, now that we have found it.

Keeping the doctor-patient relationship on a strictly professional basis is generally looked upon as good psychology. Few of us, though, have thought of it as sound economic policy.

Not long ago, a colleague of ours made an experiment apropos of this. For several months when dealing with new patients, he deliberately curbed his natural habit of being chatty and chummy. As a result, he says, his volume of services increased and his collection rate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EFFECTIVE COMPOSITION: Liver residue . . . 3 gr., Ferrous Sulphate, Exsiccated (U.S.P.). . . 3 gr., Thiamine HCl . . . 1 mg., Riboflavin . . . 0.66 mg. and Niacin . . . 10 mg.
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REG. U.S. PAT. OFF.
Tablets
Each tablet provides the raw materials universally accepted for hemoglobin regeneration, plus the raw materials for the biochemical mechanism in which hemoglobin functions.
CONVENIENCE: Easy to take . . . pleasantly flavored for chewing or swallowing.
ECONOMICAL: Budget-priced to permit protracted medication, usually required in hematinic therapy . . . cost the patient only a few cents a day.
DOSAGE: One or two tablets, three times a day, after meals.
Available, at prescription pharmacies, in bottles of 40 and 100 tablets.
Samples and literature sent to physicians upon request
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NEW YORK
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picked up considerably. Presumably, he was able to see more patients because he spent less time with each one; presumably also, new patients assumed that a physician as businesslike as he was in his managment of a case would expect his patients to be equally businesslike in the settlement of their accounts.

At all events, the doctor swears, the idea works.

In the office of Dr. Philip De Garmo at Peekskill, N.Y., stands a unique floor lamp—fashioned from, of all things, a double-barreled shotgun. Decoratively, it's quite a feature; yet the powers of suggestion being what they are, it's fortunate that the doctor is a nose and throat man and not an obstetrician.

A Birmingham (Ala.) obstetrician hands each of his OB patients a sixteen-page booklet which he—the compiler—has called "Awaiting the Stork." On its yellow cover is a warning to the prospective mother to "Read this advice every Tuesday." If she does so she will be informed on at least thirty-six separate occasions, that her doctor "ought to be a man who likes to care for obstetric cases and who takes frequent postgraduate courses in the management of such patients, in addition to having a large personal experience in the treatment of the numerous complications which sometimes arise as a result of pregnancy." She will also find out that much of the information in the booklet was "gleaned from repeated personal visitations to observe the work of numerous famous obstetricians in America" as well as from "touring Europe to become familiar with renowned maternity experts and lying-in hospitals of the Old World."

After having thus gained some insight into the rich background of the man who will introduce her to "the most sacred mystery of nature," the initiate is then told how to prepare for it. The booklet ends on this reassuring note:

"In the United States yearly, 100,000 babies are born dead; 100,000 more die before becoming one month old. There is about one dead baby in every sixteen born . . ."

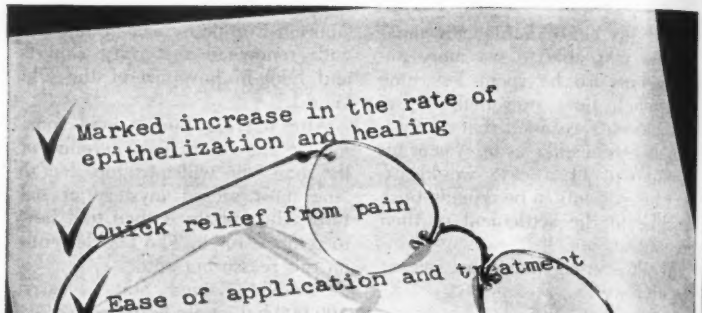
Dr. J. P. Edmundson of Kansas City, Mo., reports that a "Mrs. Maladock came into our office to be fitted with a 'diagram.' When we suggested gently that perhaps she meant a *diaphragm*, she retorted: " 'If you know what I mean, what difference does it make?' "

". . . What difference, indeed?" Dr. E. concluded.

Incidental Notes

To the overseers of the Princeton gym: If you've been spending any time in the attic recently looking for those old rubber tumbling mats, forget it! They're now on the examination tables of Dr. C. E. Fallon of Newburgh, N.Y., who hasn't any intention of giving them up.

To medical officers in the Navy: When you see a service man with letters OB on his left sleeve, halfway between the elbow and wrist, don't wonder what an accoucheur is doing in the Navy. The fellow's an ordnance man, and OB, for reasons best known to the service, is his new designation.



FOUR IMPORTANT ADVANTAGES OF THE NEW BIO-DYNE TREATMENT FOR BURNS

Biodynes bring an entirely new concept of healing and tissue repair

Continuing research and the mounting evidence of case histories indicate not one but *several advantages* which are hastening the adoption of Bio-Dyne Ointment as a standard treatment for burns.

Perhaps the most significant advantages to busier-than-ever doctors and nurses, today, are the marked shortening of the disability period brought about by *faster healing* . . . and the fact that a minimum of dressings is required.

* * *

Biodynes, like vitamins and hormones, are a major scientific discovery. They are natural cellular substances which have the power to aid cellular growth and respiration, resulting in more rapid, more effective healing.

Available from leading surgical supply houses in 15-oz. jars at $5.50; 5-lb. jars at $21.50.

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Cincinnati, Ohio

ONLY SPERTI BIO-DYNE OINTMENT CONTAINS BIODYNES

Editorial

A Cue from Management, Labor

Management, labor, and agriculture are opposed to the passage of a compulsory national service act. They prefer to attain war manpower objectives by voluntary action. The man they have to "sell" the idea to is the War Manpower Commissioner.

How can they "get next" to Paul V. McNutt?

That's easy. Since 1942 they have had a Management-Labor Policy Committee which, by Executive Order 9279, was given official status as a unit of the WMC. This nine-man body consults with Mr. McNutt on all matters of major policy and makes frequent recommendations. Although it is frankly advisory, its advice is listened to with respect and not infrequently acted upon.

On November 6, for example, it accepted the challenge to solve the war manpower problem voluntarily, issuing a concrete program for doing so. No reader of the program could fail to be impressed with its substance and its soundness. Mr. McNutt himself praised the committee's report, declaring that it was on the basis of such vigorous and forthright acceptance of responsibility that the solution of the manpower problem would be achieved. The context is much too long to reproduce here, but our leaders in the profession—particularly the members of the AMA Council on Medical Service and Public Relations—would do well to read it in full (OWI Release X-22516). Between the lines are many of the elements of a program for voluntary (and against compulsory) medicine.

Medicine needs similar representation in Mr. McNutt's department, for it is he who controls both government agencies that impinge most forcibly on the profession: the Public Health Service (under the Federal Security Agency, of which he is Administrator) and the Procurement and Assignment Service (under the War Manpower Commission, of which he is Commissioner). Although the profession cannot be expected to wield the influence in government that numerically larger groups do, it may, by becoming more active and more articulate in the right places, be able to offset the disadvantage to an appreciable degree.

—H. SHERIDAN BAKETEL, M.D.

Doctors' Incomes Rise Sharply Under Wartime Impetus

Upward climb began in 1938, study by Department of Commerce reveals

In 1942, the U.S. Department of Commerce surveyed economic conditions in five professions: dentistry, law, medicine, private duty nursing, and veterinary medicine. The surveys covered the years 1936 through 1941 and were based on a sampling by mail.

The study of medical-economic conditions was the Commerce Department's fourth in recent years. It is also regarded as its most significant one, being founded on a more adequate sample than the preceding three surveys.

Some 20,000 questionnaires were mailed to physicians. Respondents were not required to identify themselves. Returns from M.D.'s in independent practice totaled 1,816 or about 9 per cent.*

The Department of Commerce survey was confined to (1) physicians in independent practice, (2) physicians employed by such independent practitioners, and (3) part-salaried physicians receiving more than half their net income from independent practice.

The total gross income of independent U.S. physicians in 1941 is estimated by the department at about one billion dollars. This exceeds the total gross of any previous year and is 61 per cent above the 1933 depression low. Total net income also reached a new high in 1941—74 per cent above the 1933 low.

Average gross and net incomes of physicians in 1941 dropped slightly below their 1929 peaks but exceeded the record established in each of the eleven intervening years. In 1941, for the first time since comparable data became available, the average net income of independent physicians exceeded that of independent lawyers. It thus reached top position among the three major professions of medicine, law, and dentistry.

The average net income of independent physicians showed no appreciable gain from 1936 to

*The last survey of income, expenses, and related topics, made by MEDICAL ECONOMICS, covered the year 1939. It was based on returns from 7,707 physicians. Previous studies had been made by this magazine for 1935, 1933, 1930, and 1928. A future one is now in the planning stage. The Department of Commerce figures on physicians' incomes prior to 1940 tally closely with those gathered before 1940 by MEDICAL ECONOMICS. No comparison can be made with AMA figures since that association has not gathered any on the subject in the last fifteen years.

1939. But from 1939 to 1940 it rose 5 per cent, and from 1940 to 1941 it jumped 13.6 per cent.

Although accurate data for 1942 and 1943 are not available, the Department of Commerce indicates that average incomes of physicians have soared during this period. If so, the record in the last five years is as remarkable as it is unprecedented.

According to the 1940 Census of Population, 164,649 physicians were actively practicing in March 1940. Of this number, the Commerce Department believes, 128,238, or 78 per cent, were engaged primarily in independent practice, not more than 4,000 were employed by these independent practitioners, and the remainder were divided about equally between other private employment and government service.

Table 1 shows the estimated yearly number of physicians in independent practice between 1929 and 1941, together with the average gross and net incomes of those deriving all professional income from independent prac-

Table 1

ESTIMATED INCOMES OF PHYSICIANS IN INDEPENDENT PRACTICE
1929-1941

Year	*Average Number in Independent Practice (Thousands)*	*Average Gross Income*	*Average Net Income*
1929	119	8,567	5,224
1930	121	8,173	4,870
1931	121	7,191	4,178
1932	122	5,775	3,178
1933	123	5,368	2,948
1934	123	5,871	3,382
1935	124	6,295	3,695
1936	125	7,020	4,204
1937	126	7,276	4,285
1938	126	7,053	4,093
1939	128	7,261	4,229
1940	129	7,632	4,441
1941	126	8,524	5,047

Average gross and net incomes listed above are those of physicians earning their entire professional income from independent practice. Column 2 includes all physicians deriving more than half their total income from independent practice.

Table 2
AVERAGE NET INCOMES
OF PHYSICIANS
BY SIZE OF CITY, 1941

Population of City (Thousands)	*Average Net Income*
Under 1	$2,959
1, under 2.5	3,682
2.5, under 5	4,251
5, under 10	5,150
10, under 25	5,723
25, under 50	6,352
50, under 100	5,900
100, under 250	6,943
250, under 500	6,932
500 and over	4,850
Total	$5,179

tice. The decline in the number of independent physicians between 1940 and 1941 obviously reflects the transfer of such men into the armed services. The average net income of all independent physicians covered by the survey in 1941 amounted to $5,179.

A good deal of variation occurs above and below the average net of $5,179. To illustrate: About a quarter of the physicians reported 1941 net incomes below $2,000. Yet almost another quarter netted $7,000 or more. About 2 per cent went in the red for the year. Yet almost another 2 per cent reported net earnings above $20,000.

Table 2 shows that average and median incomes reach their maximum in cities of 100,000 to 250,000 population, that they are low in cities above 500,000 population and in towns under 5,000, and are lowest in hamlets of less than 1,000.

Incomes in New York City are well below those in other cities above 500,000 population and in the country as a whole. Speaking generally, the relation between physicians' incomes and city size does not differ materially from that for most other professions surveyed by the Department of Commerce.

Table 3
AVERAGE NET INCOMES
OF PHYSICIANS
BY AGE CLASSES, 1941

Age Class Average	*Net Income*
25-29	$3,135
30-34	4,234
35-39	6,292
40-44	6,477
45-49	6,760
50-54	7,097
55-59	5,294
60-64	4,574
65 and over	2,552
Unknown	3,826
Total	$5,179

Table 4
AVERAGE NET INCOMES
OF PHYSICIANS
OVER 65 YEARS OLD
BY AGE CLASSES, 1941

Age Class Average	*Net Income*
65-69	$2,981
70-74	2,125
75 and over	1,608
All Ages	5,179

Earnings of physicians increase consistently as age increases, until a peak is reached in the 50-54 year age group (Table 3). Beyond this age, the decline in earnings is pronounced.

Because of the large number of older physicians now in practice and because of their importance to the health of the civilian population during war, a breakdown of the earnings of physicians over 65 is shown in Table 4. The downward income trend among older doctors reflects in considerable degree of course a decrease in the volume of work performed.

Average and median incomes are highest in the Far West (Table 5). With minor exceptions, the Central States, the Northwest, the Middle East, New England, and the Southeast follow in descending order.

Wide variations exist among states within the same region. For instance: The average 1941 income of physicians in the District of Columbia was the highest in the nation, yet the average for the Middle East as a whole (which includes D.C.) lay below the national figure. In Alabama and Washington, physicians' incomes were also well above those in their respective regions.

During the 1936-1941 period, inclusive, costs of practice averaged 41.3 per cent and net income averaged 58.7 per cent of gross income. Although these ratios varied slightly from year to year, they were, on the whole, very stable.

Respondents to the Department of Commerce survey were re-

[*Continued on page* 170]

Table 5

AVERAGE NET INCOMES OF PHYSICIANS BY AREAS, 1941

Region and State	*Average Net Income*
New England	$4,739
Connecticut	5,927
Massachusetts	4,333
Middle East	4,900
District of Columbia	7,610
Maryland	4,803
New Jersey	5,187
New York	4,746
Pennsylvania	4,755
West Virginia	5,222
Southeast	4,586
Alabama	5,153
Arkansas	2,834
Georgia	4,818
Kentucky	2,995
Louisiana	4,961
Mississippi	3,236
Virginia	4,649
Southwest	—
Central States	6,142
Ohio	7,167
Northwest	5,064
Kansas	4,296
Utah	4,429
Far West	6,552
California	5,400
Oregon	6,417
Washington	8,016
United States	5,179

Data have been omitted for those states seriously under-represented in the sample. Similar data have also been omitted for Texas and the Southwest region because of an over-representation of older specialists in the larger cities there.

Complete Diagnostic Service Fits Middle-Income Pocketbooks

New York's Mount Sinai group helps G.P.'s solve a major problem

Sooner or later, practically every general practitioner finds himself up against a problem that calls for the facilities of a complete consultation service. Perhaps he has a patient of limited means who is suffering from an obscure ailment. How is the G.P. to obtain diagnostic assistance without completely surrendering his patient to a private or public clinic?

Of course, the profession has made a number of attempts to solve this problem, but for one reason or another—financial insufficiency, forced dependence on the facilities of the public clinic, etc.—the results have not always been happy.

It has been demonstrated, however, that such a service can succeed. Mount Sinai Hospital, in New York City, established a consultation service twelve years ago, and today it is still running efficiently, despite wartime difficulties. The service still holds to its original program: (1) no competition with private practice; (2) ethical integrity—assuring the return of patients to referring physicians; (3) complete diagnostic services; (4) flat fees, low enough for patients with modest incomes; (5) fair compensation for staff diagnosticians; (6) a self-supporting financial structure.

Eligibility for the Mount Sinai service is limited to referred patients with maximum incomes of $2,400 a year for a single person, and $4,000 for a family of five or less, plus $400 a year for each additional member.

Guarding against any possible identification with the hospital's outpatient department, the consultation service is housed in another building, the semi-private pavilion, where it functions as an independent unit. Its consulting group includes all the internists, surgeons, and specialists who are members of Mount Sinai's visiting staff.

Only private practitioners may arrange for consultations, and they are urged to accompany their patients whenever possible. Hours for first visits are from 1:30 to 4 P.M. on Mondays, Wednesdays, and Fridays. Patients return on intervening days for a series of diagnostic tests, confirmatory examinations, etc.

Each patient is charged a flat fee of $35, regardless of the nature of the illness or the number of consultations or laboratory tests required. This fee, about double the average charge to a patient of this class for a single individual consultation or a major laboratory examination, was set by the Mount Sinai service to minimize conflict with the practice of private consultants. The hospital itself derives no benefit whatever from the service.

At the first visit, the patient gives satisfactory evidence of eligibility and pays his fee. He is then interviewed briefly by the associate medical director, and examined by staff physicians—first generally and afterwards specifically as indicated. Patients average five visits; two to three weeks usually complete a case.

In no case is treatment given or discussed with the patient. Complete diagnostic findings are submitted direct to the referring doctor, together with detailed advice concerning therapy. If the practitioner so wishes, he may avail himself of the assistance of the consulting staff in carrying out recommended treatments.

That doctors like the service is indicated by its popularity: Approximately a third of the M.D.'s in the New York metropolitan area have referred one or more patients to the Mount Sinai organization. At present, appointments must be made three to four weeks ahead, so great is the demand for consultations.

Self-supporting since its third year, at which time it was some $14,000 in the red, the service's annual gross income is now more than triple that of its first twelve months' operation. The deficit has been wiped out, a reserve built up for equipment, and part of the original loan of $15,000 (advanced by the hospital) has been retired.

Half the gross goes to the doctors, half to the hospital. Individual physicians are compensated monthly in accordance with the amount of time they have spent. Specialists average $6.50 to $7.50 per consultation; an internist who devotes three afternoons a week to the clinic averages $150 to $180 monthly. Consultants doing a large share of the work may earn up to $400 a month.

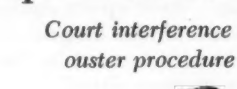
The hospital's share of the gross income is divided between retirement of the original loan and current expenses; the latter includes salaries (of nurses, technicians, and secretaries), supplies, and other operating costs. No charge for rent or for interest on the loan is made by the hospital.

Like all other medical organizations, the service has been hit hard by the war; many of its staff have gone into the armed forces. But by spreading the load over those who remain, Mount Sinai has thus far been able to handle its normal number of consultations.

—HARRY W. BLAKELEY

Law Gives Societies Right To Expel Unethical Members

Court interference unlikely if ouster procedure is sound



When a medical society's disciplinary board is weighing the expulsion of a man whose conduct it considers unethical, a cautious member of the tribunal is likely to warn his fellows: "We'd better go easy. He might sue us!" Many doctors, it seems, suffer from a sort of legal hypochondria, probably induced by uncomfortable sessions in court as expert witnesses.

It's entirely possible, of course, that a disgruntled member who has been expelled for violation of professional ethics may sue for reinstatement or for monetary damages. But the chances are against an attorney's taking his case. If he did, it's even more unlikely that the suit would be successful. For the law gives voluntary societies, whether incorporated or not, wide powers for the expulsion or discipline of errant members. The legal principles governing such authority were laid down many years ago.

As a matter of fact, we owe the established precedent to one man. He was an Englishman, a Colonel Dawkins, who was afflicted with what Professor Chaffee of Harvard has described as a "litigatious variety of mental disease." The doughty colonel spent a great deal of his time in court seeking redress for all sorts of wrongs—real or imaginary—against his person or his rights. It was in one of these suits—an action in 1881 by which Dawkins sought to have a court set aside his expulsion from the Travelers Club of London—that several widely accepted principles of equity jurisprudence were stated for the first time.

In trying Dawkins' case the court set up three tests by which it could determine whether the colonel had been wrongfully expelled and was thus entitled to legal relief: 1. The rules and proceedings under which the society expelled Dawkins must not have been contrary to natural justice. 2. The expulsion must have been in accordance with the established rules. 3. The proceedings must have been free of malice or bad faith.

Since that time the same three tests have been applied by all courts, in England and the United

States, that have been called upon to adjudicate a similar suit. State courts here have quite generally held that a proceeding by a voluntary society for the suspension or expulsion of a member is quasi-judicial in character. Consequently they will not interfere, upon appeal of a decision, except to ascertain whether the society acted (1) in good faith; (2) in accordance with its own by-laws; and (3) according to the common principles of justice.

American courts generally maintain (though some legal scholars offer theoretical objections) that the constitution and by-laws of a society constitute, in effect, a contract between it and its members, based on the fact that a man gives tacit approval to existing rules when he joins a society, and affirms rules subsequently adopted by retaining his membership.

Thus a member makes himself subject to discipline, as specified in those by-laws, for a violation of the ethical code of the profession. And while it is desirable for the society to incorporate definite provisions for disciplinary action in its by-laws, lack of them will not induce a court to interfere except to determine whether the common principles of justice have been adhered to.

This being the case, a society should test its procedure in disciplinary action by the following legally accepted standard. If it measures up, the association can rid itself of an undesirable member without fear of judgment for damages.

1. When rules for disciplinary procedure are incorporated in the society's by-laws, they should be followed scrupulously. (If there is no established procedure, it is only necessary that the proceedings be fair and free from malice.)

2. Grounds for expulsion should be reasonable and just. (But some courts have held that this test is not applicable when grounds for expulsion are specified in the by-laws.)

3. Notice of preferred charges must be given the accused. They need not be written unless the by-laws so prescribe. (The accused waives any claim of insufficiency of notice by appearing before the society's tribunal and defending himself.)

4. The by-laws may properly deny the accused a jury trial or the right to counsel.

5. The accused must be given an opportunity to present evidence to refute charges.

6. The accused member must exhaust appeals or remedies afforded by the society before a court will intervene.

7. Strict legal procedure and juridical rules of evidence need not be observed.

8. A member-prosecutor should never take part in the deliberations or vote of the tribunal.

9. No member of the tribunal who has not been present to hear all the evidence should be allowed a voice in its decisions.

—MAC F. CAHAL, J.D.

GENERAL POLICIES OF AMA

Pursuant to carrying out the duties imposed on it by the House of Delegates, the Council has adopted the following general policies:

1. The Council on Medical Service and Public Relations recognizes the desirability of widespread distribution of the benefits of medical science; it encourages evolution in the methods of administering medical care, subject to the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered. It is not in the public interest that the removal of economic barriers to medical service should be utilized as a subterfuge to overturn the whole order of medical practice. Removal of economic barriers should be an object in itself. It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased, and that graduate and postgraduate medical education be energetically developed. Curative medicine, preventive medicine, public health medicine, research medicine, and medical education, all are indispensable factors in promoting the health, comfort, and happiness of the nation.

2. The council through its executive committee and secretary shall analyze proposed legislation affecting medical service. Its officers are instructed to provide advice to the various state medical organizations as well as to legislative committees concerning the effects of the proposed legislation. It shall likewise be the duty of its officers to offer constructive suggestions to bureaus and legislative committees on the subject of medical service.

3. The council approves the principle of voluntary insurance programs but disapproves the inclusion of medical services in those contracts for the reasons adopted by the House of Delegates at the 1943 meeting.

4. The council approves voluntary prepayment medical service under the control of state and county medical societies in accordance with the principles adopted by the House of Delegates in 1938. The medical profession has always been very much opposed to compulsory health insurance because (1) it does not reach the unemployed class, (2) it results in a bureaucratic control of medicine and interposes a third party between the physician and the patient, (3)

A commentary on this statement of policies begins on page 50.

it results in mass medicine which is neither art nor science, (4) it is inordinately expensive, and (5) regulations, red tape, and interference render good care impossible. Propaganda to the contrary notwithstanding, organized medicine in general and the American Medical Association in particular have never opposed group medicine, prepayment or non-prepayment, as such. The American Medical Association and the medical profession as a whole have opposed any scheme which on the face of it renders good medical care impossible. That group medicine has not been opposed as such is evidenced by the fact that there are many groups operating in the United States which have the approval of the medical profession, and members of these groups are and have been officials in the national and state medical organizations. That group medicine is the Utopia for the whole population, however, is not probable. It may be and possibly is the answer for certain communities and certain industrial groups if the medical groups are so organized and operated as to deliver good medical care.

5. The council believes that many emergency measures now in force should cease following the end of hostilities.

6. The council believes that the medical profession should attempt to establish the most cordial relationships possible with allied professions.

7. There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the nation as a whole, it is the opinion of the council that the medical profession may well support the activities of the National Physicians Committee and other organizations of like aims.

8. American medicine and this council owe a responsibility to our colleagues who are making personal sacrifices to answer the call of the armed forces. Therefore, the council expresses the desire to cooperate with the medical committee on post-war planning in order to assist our colleagues in reestablishing themselves in the practice of medicine, and in the preservation of the American system of medicine.




Dr. A. W. Adson Brig. Gen. F. W. Rankin Dr. W. S. Leathers Dr. James R. McI*

Medical Service Council Scored

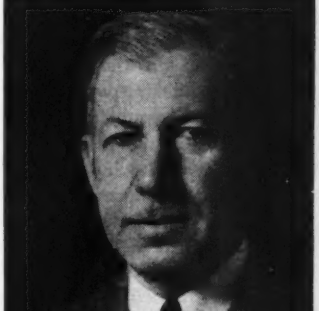
Vital and urgent job before AMA body

Last June, on a note of high enthusiasm, the AMA established its Council on Medical Service and Public Relations. The objectives of the council are apparently to devise plans for the better distribution of medical care and to work closely with local medical societies in implementing those plans.

AMA President James E. Paullin heralded the organization of the council as "a great step forward." The press predicted that it would "streamline" medical practice in America. More than one rank-and-file physician hoped it might emerge as medicine's savior, delivering it from the threat of bureaucratic domination.

Six months have now passed. What has the council accomplished? Here is the record:

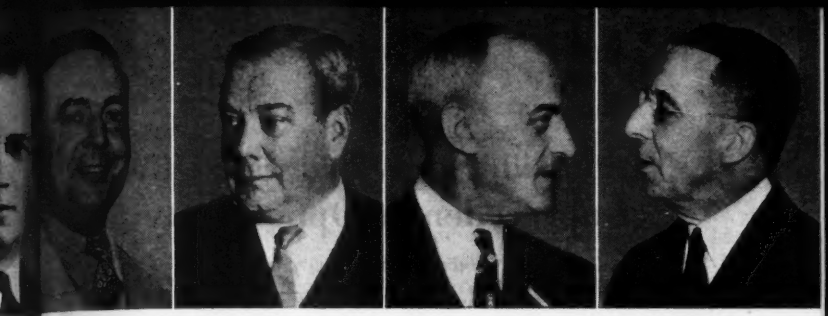
(1) It has adopted a set of general policies.† (2) It has determined how it will function. (3) It has analyzed the Wagner bill. (4) It has notified constituent medical societies of its analysis of the Wagner bill. (5) It is studying government-subsidized maternity care and the rehabili-



Council Chairman Louis H. Bauer

*Not shown is Dr. John H. Fitzgibbon, another council member.

†See pages 48, 49.



E. J. McCormick *Dr. Roger I. Lee* *Dr. Olin West* *Dr. J. E. Paullin*

For Its 'Snail-Like Progress'

said to demand prompt all-out effort

tation of demobilized doctors after the war. (6) It has asked the constituent medical societies to designate committees that will act as regional agents. (Some have complied.)

At the beginning of its sixth month, the council had decided what its general policies would be. As soon as the statement of these policies was released, copies were made by this reporter and discussed with a number of representative private practitioners. Impatience characterized most of the opinions expressed. The majority of those interviewed stressed the magnitude and urgency of the job to be done. "God help us," they said, in effect, "if it isn't done soon!"

Questions asked by these men were many and varied. The more significant ones were presented to a spokesman of the council for reply. Following are the queries made and the answers received:

What does the council expect to have accomplished by June 1944?

Answer: As complete a study as possible of medical care—to see how things can be improved and what modifications of the present structure should be made. Support of all activities designed to improve the general health of the public. Retention of the present medical system as a foundation, with such modifications as may be necessary.

Why has the council made such slow progress?

Answer: It has been handicapped by not having a permanent secretary.

Has the council distributed an analysis yet of any legislation besides the Wagner bill?

Answer: No.

Since the Wagner bill had al-

[*Continued on page* 112]

Nationwide Study Program Offers Unprecedented Opportunity

Civilian as well as military physicians welcomed at post-graduate sessions

Are you missing something? You may well be if you're not attending the War-Time Graduate Medical Meetings now being sponsored from coast to coast by the American Medical Association, the American College of Physicians, and the American College of Surgeons.

This post-graduate medical study project, initiated last spring, has now mobilized the largest and most distinguished teaching staff in the history of American medicine: a staff capable of giving truly superb instruction to thousands of doctors—and free of tuition fees.

Nationwide in scope, the project aims to pool the magnificent teaching resources of the country's medical schools, making post-graduate instruction available to physicians both in the armed forces and on the home front. It has the wholehearted endorsement of the deans and faculties of fifty-five of these schools, as well as the authorization of the Surgeon Generals of the Army, Navy, and Public Health Service. These organizations recognize fully that now, in wartime, the curtailed activities of teaching institutions seriously limit the civilian doctor's opportunity for post-graduate study.

The fact that the instruction is given, for the most part, at army and navy hospitals and camps does not mean that civilian doctors are not welcome. On the contrary, they are urged to attend in greater numbers than up to now. Those who *have* attended say that their confreres who fail to take advantage of the present opportunity are missing the chance of a lifetime.

In a nutshell, here's how the program works:

1. The country has been divided into twenty-four sections. (Generally, these divisions follow state lines.) In each section, a regional committee of three doctors arranges the time and place of the meetings.

2. Available to the regional committees is a national faculty consisting of 1,200 physicians, the cream of the country's medical teaching talent. Among them, these doctors represent some twenty-eight specialties and subspecialties.

3. On the request of the commanding officer of any military establishment in the country, the regional committee in that area arranges an instruction course of one to six days' duration in the particular subject or subjects desired. Choice of the instructor rests with the committee, which —if need be—can seek the advice of the program's national consultant in that specialty. (Thirty-one national consultants represent the program's twenty-eight specialties.) If need be, the committee can obtain an instructor from outside its own area; though this is seldom necessary, so extensive is the faculty list.

4. Instruction takes the form of ward rounds, clinics, practical demonstrations, motion pictures, lectures, and conferences.

So that civilian doctors may know when and where these meetings are to be held, the regional committees maintain constant liaison with the state and county medical societies in their districts. Schedules of forthcoming programs are submitted to these societies as well as to the national, sponsoring bodies.

To attend a given meeting, a civilian doctor need merely apply by mail to the commanding officer of the establishment where the instruction is to be given, requesting the usual pass necessary for admittance. No registration fee or tuition charge is required; but the physician must, of course, pay his own transportation and keep. The regional committees are not expected to make arrangements for overnight stays; yet in most cases they can supply information about accommodations, and are glad to do so. (Names and addresses of the committee chairmen in the various regions are available from MEDICAL ECONOMICS on request.)

Civilian doctors are advised, first of all, to have their names placed on the mailing list of the headquarters committee. This can be done by dropping a postcard either to your regional chairman or to the Central Committee, War-Time Graduate Medical Meetings, 4200 Pine Street, Philadelphia. Mimeographed schedules of meetings as well as general literature concerning the program are mailed regularly to those whose names are on the list.

That this program of post-graduate instruction is off to a good start is indicated by the record: Since last May when the first meeting took place, some seventy-five similar ones have attracted an attendance of nearly 5,000 physicians. Most of the attendants have been members of the armed forces, but enough have come from civil life to prove that the effort fills a long-felt need.

Indications are that more civilian doctors will take advantage of the instruction as they learn of it and as the program develops. The opportunities presented have never before been equalled in this country; and the national faculty represents an array of talent that could not be matched

anywhere in the world today.

Of no small significance is the fact that the cost of the program is being borne by the three sponsoring organizations; not one penny is being contributed by the government. Faculty members give their services free up to and including the fourth day of each meeting; if a course runs longer than that, they receive an honorarium of $25 a day. Their traveling expenses are paid from the project's operating funds.

Some civilian doctors seem to have gathered the impression that the subject matter of the meetings relates only to military medicine. This is not so—though naturally one would hardly expect a lecture on pediatrics at an army or navy hospital. By and large, the instruction covers subjects important to civilian doctor and medical officer alike. Note, for instance, the topics covered in a typical three-day meeting held at the Newport (R.I.) Naval Hospital:

Chemotherapy, including a discussion of penicillin, by Dr. Chester S. Keefer.

Coronary Disease, by Dr. Harold M. Marvin.

Atypical Pneumonias, by Dr. Francis G. Blake.

Rheumatic Fever, by Dr. T. Duckett Jones.

Tuberculosis: Case Findings in the Selective Service and the Relationship of TB to the Civilian Army, by Dr. Paul S. Phelps.

Meningitis, by Dr. Kalei K. Gregory.

Neuropsychiatry and the War, by Dr. Arthur H. Ruggles.

Tropical Diseases, with special reference to *Malaria,* by Dr. Roswell D. Johnson.

Anesthesia and Inhalation Therapy, by Dr. Meyer Saklad.

Aviation Physiology, by Dr. John F. Fulton.

Peptic and Duodenal Ulcer, by Dr. Chester M. Jones.

Syphilis: Diagnosis and Treatment, by Dr. Oscar F. Cox.

National Research Council: Projects in War Surgery, by Dr. Samuel C. Harvey.

Treatment of Thoracic Trauma, by Dr. Gustaf E. Lindskog.

Traumatic Surgery of the Abdomen, by Dr. Charles C. Lund.

Peripheral Nerve Surgery, by Dr. Henry C. Marble.

Fractures of the Long Bones, by Dr. Gordon M. Morrison.

Advances in the Treatment of Shock, by Dr. Milton C. Winternitz.

At this particular meeting in Newport, an hour's discussion was devoted to each of the above subjects. Other meetings give less (or more) time to each topic, as immediate needs dictate. A primary purpose is, obviously, to broaden the medical knowledge of the 40,000 or more physicians now in the armed forces. Yet as can readily be seen in the subject matter taken up at Newport, the needs of the civilian M.D. are not slighted; and many a family physician who has attended such meetings has been

[*Continued on page* 128]

Army Medical Intelligence Surveys Foreign Areas

Health and sanitation program can be instituted as troops land

As a result of the little-publicized work of the Army's Medical Intelligence Branch, a subdivision of the Division of Preventive Medicine of the Surgeon General's Office, medical officers who accompany American forces to foreign areas anywhere in the world know what health and sanitation problems they are going to run into before a soldier walks down a gangplank or a landing craft scrapes on a beach. When the Allies invaded Italy, for instance, our medical officers knew as much about Italian malaria as the Italians did themselves.

"Our major job is to have ready, when the Army needs it, all possible medical, sanitary, and health intelligence about any area in the world, outside the United States, in which the exigencies of global war may make it necessary for American troops to serve," is the way its activities are briefed by Lieut. Col. Gaylord W. Anderson, commanding officer of the Medical Intelligence Branch.

The words "information" and "intelligence" often are used interchangeably, but in military parlance they are not synonymous. Information is raw material. Processed by evaluation and interpretation it becomes intelligence, a more or less finished product.

The principal function of the Medical Intelligence Branch is the gathering, from many sources, of all obtainable information of military-medical interest about areas in which our troops may be called on to serve, and the processing of it into trustworthy military-medical intelligence. This serves as a guide to the proper outfitting of troops ordered on foreign service, and enables their medical officers to plan sensible protection against disease, which in almost all past wars caused more casualties than enemy bullets. A secondary mission is the gathering of information, unobtainable through other channels, about the military-medical practices of the armies of our allies and our enemies. The MIB does not concern itself with health and sanitary conditions in the United States; these are the responsibility of the Medical Department of the Army.

[*Continued on page* 130]

Gains Made in Fight to Give Workmen Free Choice

Compensation laws of half the states now guarantee it to some degree

Organized medicine has long championed the right of the patient to choose his own doctor. In medical service plans for the general public, for the indigent, and for fraternal and other groups, the profession has steadfastly advocated this principle. One of its hardest struggles has been to get state legislatures to recognize the right of free choice under workmen's compensation.

The fight is not yet won. Employers and insurance companies still argue against the principle—even in states where it has been legally adopted. But the old arguments are beginning to wear thin. The profession is gradually proving to legislators the soundness of free choice in actual practice.

Legislative reforms in New York have been important enough to affect favorably the practices of 95 per cent of the state's doctors. Similar reforms have been and are now being urged elsewhere. The result to date is that about half the states currently have statutes giving workmen some degree of free choice. Rhode Island and Massachusetts laws specially confer this right. Utah law has been construed by the courts as conferring it. In Pennsylvania the employe must request permission to choose his own doctor, stating why he wants to do so; but permission is usually granted. In Nebraska, he may select his own surgeon when a major operation is involved.

Although in the last ten years the reforms cited have all been achieved, much remains to be done: Half the states have yet to prescribe free choice by law. In those that do prescribe it, the choice should be, as nearly as possible, *completely* free. And, finally, when the right of free choice has been conferred by law, those who enjoy it must guard against its unlawful usurpation. The need for vigilance has been demonstrated even in New York State—which is said to have the best compensation law yet devised.

Everyone admits that a workman injured at work is entitled to medical care at no expense to himself. All compensation laws make provision for this. The controversial issue that arises con-

cerns the *adequacy* of the medical care given; and such adequacy depends, of course, on the choice of the physician.

Too often, the law of a state specifies that the doctor shall be chosen by the employer (or his insurance carrier). Under the circumstances, the emphasis may be on the *cost* of the service rather than on its *quality*. Without the right to select his own physician, the injured workman must either take whatever medical care is offered or suffer the injustice of having to pay his own doctor's bill.

Nor have abuses been limited to such things as the employment of unqualified (and sometimes unlicensed) physicians. A good many commercial clinics have sprung up, staffed mainly by nurses, ex-orderlies, and former medical students. These clinics have offered employers and insurers "medical care" on a mass-production basis. Some insurance companies have gone so far as to create such clinics themselves, employing a qualified physician only when faced with the treatment of a severe injury involving substantial legal claims.

Absence of the right of free choice has also led to abuses by an unethical minority within the profession itself. "Kickbacks" have been paid freely and doctors have openly solicited industrial cases. Some practitioners have even sold themselves to insurance companies as lawsuit witnesses, to defeat employes' claims.

Still another evil has cropped up in states where there is no right of free choice, and that is the pernicious practice of case-lifting. Many a thoroughly competent physician has had the care of a patient suddenly taken out of his hands by an insurance company that wanted the man back on the job prematurely—to economize on compensation payments.

Why has it been so difficult to convince legislators that the compensation laws of their states should be amended to provide free choice? Mainly because of the arguments put forth by the opposition—arguments which medicine was unable to combat until it proved that the free-choice principle was *practical* as well as just. In the light of such proof, the old arguments should now be re-examined.

Take, for instance, the familiar contention that a company's own medical department is better qualified to handle industrial injury cases than an outside doctor is, and that free choice is thus unwise. The answer is that if the department measures up to the claims made for it (which it may well do), the injured workman, under free choice, will probably consult it in preference to a doctor on the outside. There is actual evidence of this in many states that have adopted the free choice principle. At all events, the mere fact that a firm or its insurance carrier claims superior medical facilities is no reason for

denying an injured man the right of free selection.

Take, also, the frequently heard argument that the employer foots the bill and should therefore choose the physician. Actually, all money paid out for compensation is part of the cost of doing business and, in the final analysis, is paid by the consuming public. In the meantime, such money is nothing more than a trust fund set up to protect the injured worker, and should not be subject to the manipulations of employers and insurance companies.

Consider, too, the claim that private physicians sometimes overtreat compensation cases, charge excessive fees, and deliberately delay the patient's return to work. Safeguards against such dishonesties can be (and are) provided under free choice: Permission can be given to have the injured worker examined periodically by a doctor chosen by the employer. In New York, the act provides for this—specifying only that the examination be made in the presence of the worker's own doctor.

Where free choice exists, and the rights of all parties are protected by arbitration, employers and insurance companies have come to recognize the folly of claiming that doctors in general are dishonest. In compensation cases submitted for arbitration, poor quality of medical care is seldom cited as a reason why a doctor's bill should not be paid. Employers and insurers alike have learned that most physicians conscientiously fulfill their obligations to those who foot the bills. They have also learned that the confidence of the patient in the doctor of his own choosing is an important factor in his recovery.

It has sometimes been argued that the employer, because of greater intelligence and wider experience with accident cases, is a better judge of medical talent than the workman. Actually, of course, few employers make the choice; it is usually delegated to the insurance carrier—whose primary aim is economy.

It has also been maintained that the employer or the insurer will choose wisely because both wish to get the worker back on the job as soon as possible. This may or may not be so, for the fact remains that the cost of the medical care rather than its quality is their principal concern.

In arguing for free choice, the profession should not overlook another important advantage that employers and insurers seek in opposing it: namely, the control of records of diagnoses and treatment. Equitable settlement of claims is often impossible when testimony must be based on the records of insurance company physicians. Free choice, on the other hand, gives the workman a reasonable chance before a referee, a judge, or a jury.

An outstanding feature of the New York compensation law is

[*Continued on page* 118]

WHY DO IT THE HARD WAY?

A few hints that should help you increase your efficiency

"I've so many things to do I don't know where to start!" If you often say this to yourself, here's a suggestion:

When you begin work in the morning, take a few moments to preview your tasks for the day. List each function briefly on a separate 3" x 5" slip. Arrange the slips in order of importance. Then do the work in the same order.

As a chore is completed discard the slip relating to it. As new ones arise, write out slips listing each and insert them in the proper chronological sequence. You'll thus have a sort of perpetual inventory of work to be done. Go over it each morning, adding new slips and rearranging leftover ones in the new sequence.

• • •

If you like, you can add a time estimate to each task slip. This makes it possible for you to forecast about how much work you can accomplish in a given day. It also spotlights jobs for which you may not have time, serving as a reminder to delegate the work or to write a letter postponing or declining it altogether if it can't be done in the near future.

• • •

Slips may be kept in your desk with a rubber band around them. If every job to be done is listed religiously on its own slip, and if the batch is added to, substracted from, and rearranged daily in the most advantageous sequence, it will prove its value in short order.

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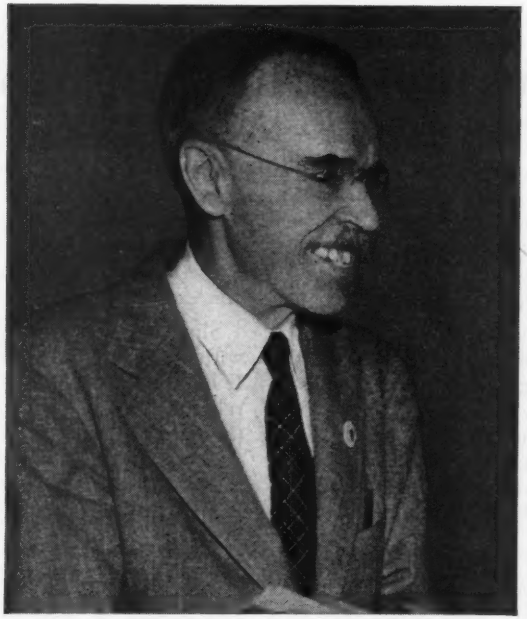
Your secretary can also use the slip system to advantage since it assures doing first things first and prevents tasks from being forgotten. Furthermore, if certain chores have been assigned to her by the doctor, and if they are listed on slips, the latter can be reviewed, say weekly, as a means of checking on what progress she has made.

When you're doing desk work, finish each job before plunging into another. The slip method described should help appreciably in this respect. Too many of us have the wasteful and confusing habit of leaving one unfinished task, taking up another, dropping that for a third, and so on.

[*Continued on page* 114]



Dr. Paul Dudley White

MGH's PDW

A great cardiologist adds luster to an historic Boston name

Much of what has been learned about heart disease in the past thirty years can be credited to the Massachusetts General Hospital and to its staff member Paul Dudley White.

History, of course, honors MGH as the place where ether was first administered; for it was in the dome of the old Bulfinch Building, now the hospital's "ether museum," that this famous event took place on October 16, 1846. Yet physicians of the future may come to regard the basement of that building as a spot to be revered too; for it was there that Dr. White installed one of the first electro-

cardiographs ever used in America—a machine which eventually wrote 21,160 electrocardiograms and proved a priceless factor in advancing the study of heart disease.

He brought the device—an Einthoven string galvanometer—to this country from Cambridge, England in the fall of 1914. He had just finished a year of postgraduate study in London under Sir James Mackenzie and Sir Thomas Lewis, after having completed his interneship at Massachusetts General a year before.

Cardiology at that time was considered much too narrow a field for specialization. Many of young White's colleagues warned him that he'd find little to do if he devoted all his talents to it. When he installed his electrocardiograph, both he and the instrument were looked upon with dour misgivings by the relatively few physicians who had ever heard of it. Most of them regarded it as little better than the sphygmograph, a rather clumsy device, invented in the 1880's, to record pulse activity.

At it turned out, installation of the new galvanometer inaugurated the great cardiac program which has been carried on at MGH ever since under Dr. White's leadership. The work was interrupted for a time during World War I; but since 1920, when it was resumed, scores of heart specialists have been trained there and thousands of patients have been treated.

Extremely modest, Paul White takes little credit for his accomplishments. More often than not in the hundreds of scholarly papers he has prepared, he has chosen to share credit for a discovery with some young assistant who had but a part in the research. In the same spirit, he maintains that he has merely built upon the foundation laid at MGH—while he was still a medical student—by Drs. Richard C. Cabot, Henry Jackson, William H. Smith, Roger I. Lee, Joseph H. Pratt, and David L. Edsall.

Nevertheless, his former assistants (who have numbered as many as fourteen at once) insist that to Paul White rightly belongs a lion's share of the glory for advancing the study of heart disease in the United States in our time.

One reason why the White name is so closely associated with that of MGH is the fact that his only office has always been located in the old Bulfinch Building. Furthermore, for several years prior to his marriage in 1924, he maintained bachelor quarters at the hospital. He could be found there regularly, working late at night and in the early morning hours.

Dr. White's capacity for work often astonishes people. Not only does he maintain a prodigious practice, but he also finds time for many other activities. Colleagues say the answer lies in his ability to organize his work.

An omnivorous *reader* of medical literature, he also finds time

to *write* it, having prepared many papers and a number of books. His *magnum opus*, "Heart Disease," which runs to 931 pages, was published in 1931 and revised in 1937. He has now completed still another revision, which is scheduled for publication in 1944. His regimen also includes talks before medical societies and the pursuit of his one hobby: collecting rare medical books.

A man so engrossed in his work is bound to conjure up a mental picture of a coldly scientific individual with few warm human qualities. Yet those closest to him know that he is quite the opposite—a charming companion, a gracious host, and a lover of simple New England traditions.

Dr. White was born in Boston's Roxbury section in 1886. He was graduated from Harvard in 1908, and from Harvard Medical School in 1911 (he now teaches there). In addition to his year of study in London in 1913-14, he put in a year of postgraduate work in Vienna in 1928-29. He has a wide acquaintanceship with medical men in Great Britain, on the Continent, and in South and Central America.

During World War I, he served first with the British, transferring later to the American Expeditionary Forces. With the AEF, he was stationed at Base Hospital No. 6, near Bordeaux, where, among other things, he carried on his cardiac studies by staging baseball games to test the reactions of convalescent soldiers. Three months after the Armistice, when Captain White received his discharge, he organized the Greek Medical Unit of the American Red Cross, for service in Eastern Macedonia. For his work there he was decorated twice by the Greek Government.

One of the organizers, in 1923, of the American Heart Association, Dr. White has continued to take an active part in many phases of its work—serving for two years (1941-42) as president. He is a Fellow of the American College of Physicians and of the American Medical Association, chairman of the committee on cardiovascular disease of the National Research Council, and a member of many other professional societies here and abroad.

An inch or so under average height and slight of build, Paul White belies his tremendous capacity for work. He seems to thrive on routine—for none of his friends can recall that he has been seriously ill for any extended period in the past twenty years or more.

The White town house is in the Chestnut Hill section of Brookline. But some years ago the doctor acquired a small farm some thirty-five miles from his office in Boston.

There he spends his weekends with his wife, their two adopted children, and the teen-age daughter of Sir Thomas Lewis, whose father has placed her in the Whites' care for the duration.

—GLENN T. PARKER

PHS Calls Doctor-Population Ratio a 'Crude Index'

Says it helps little in determining how many doctors an area needs

The ratio of physicians to population—when used as an index of the adequacy or inadequacy of medical care—isn't worth much. At least that is the conclusion reached by the U.S. Public Health Service in a report entitled, "The Patient Load of Physicians in Private Practice."

The PHS warns against assuming that a community's medical needs are being met simply because it has a high proportion of doctors to population—or vice versa. This ratio, it says, is only the crudest yardstick; the adequacy of medical care depends not only on the relative supply of physicians but—even more—on the relative demand* for their services. A thousand people in one area may demand twice as much service as a thousand in another area. To the extent that the demand is legitimate, the doctor-population ratio should be adjusted, the survey report of PHS declares.

The present patient-load report is based on an analysis of mail questionnaires completed by 2,675 physicians in the District of Columbia, Georgia, and Maryland. It reflects wartime conditions in these areas, for the statistics were gathered in 1942 after some 30 per cent of active practitioners had entered the armed forces.

"It is a fallacy to assume that a large number of physicians per unit of population indicates an oversupply . . . of physicans, or a small number an undersupply," the Public Health Service asserts, adding that in Maryland the number of persons per physician could be increased to 1,200 to 1,500; but in Georgia, because the demand for services is much lower, it could reach 2,000 to 2,400. Although these numerical results are to be accepted with caution, it seems safe to generalize that in different populations utilization of the full working capacities of physicians may be achieved at different levels of ratio of physicians to population." Hence, the PHS reasons, "any plan aimed at utilizing fully the medical resources of a popula-

*"Demand," used here in the strict economic sense, is not to be confused with "need" for medical services. The number of persons actually seen by physicians does not, except under ideal conditions, equal the number of persons needing medical care.

tion must be founded on accurate knowledge of the demand for physicians' services and of the amount of work physicians are able to do. Such knowledge can only be gained from data on the patient load or its equivalent."

At the time the study was made, the District of Columbia had 840 persons per physician, Maryland had 1,190, and Georgia had 1,760. These areas differ considerably in social and economic characteristics as well as in medical facilities. In Georgia, for example, the average white male G.P. sees 111 patients weekly; his colleague in Maryland sees 126; his District of Columbia colleague, 115. Among them, they average 118 patients per week.† About 71 per cent of these patients are seen at the office, 6 per cent at hospitals, and the remaining 23 per cent at their homes.

Paradoxically, the older G.P.'s make relatively more house calls than do the younger ones. And as might be expected, specialists (with the exception of pediatricians) make very few house calls.

In the larger cities, G.P.'s average 5.2 hours per day in their offices. Rural practitioners devote 6 hours a day to office patients. Older physicians keep only slightly shorter office hours than the younger men.

†This magazine's pre-war Survey of Medical Practice in 1939, in which 7,707 U.S. doctors cooperated, reported the average number of patients seen daily by physicians as fifteen. See May 1941 issue for detailed breakdowns.

A breakdown of the patient load in Georgia showed that urban G.P.'s average 112 patients a week, rural ones 111. Asked to state the largest number they could see and still furnish satisfactory care, 60 per cent of the urban G.P.'s said they could increase their present patient load to an optimum figure (averaged) of 129 patients weekly per physician. Only 49 per cent of the rural G.P.'s said they could handle more patients; these men guessed that the rural weekly average might be upped to 123.

The report points out that these averages do not represent the maximum possible load of the Georgia physicians. The estimates given assume prevailing conditions; under better conditions, more patients might be seen. If, for example, it were possible to limit practice more to the office and to arrange scheduled visits at a more constant rate, the maximum working capacity of the average G.P. would lie somewhere between 125 and 160 patients weekly, the PHS estimates.

The report goes on to reveal how urbanism and economic considerations affect medical care. In the areas studied, it says, the annual number of calls or services per person, rendered by private practitioners, is as follows:

Baltimore	6.2
District of Columbia	5.9
Urban counties of Georgia	4.9
Maryland (excluding Baltimore)	3.4

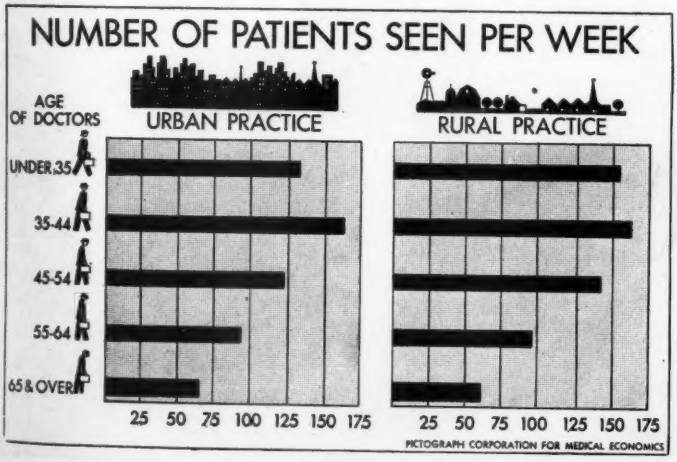
Rural counties of
Georgia 2.5

The report calls attention to the fact that the higher number of services per person in urban areas is due in part to the flow of patients to cities where medical centers are located. So far as the doctors in such cities are concerned, this has the effect of an increase in population.

The figures compiled by the PHS makes it possible to estimate what the patient load of the physicians remaining in private practice would be if a stated number of doctors were withdrawn from the areas studied. Because of the large number of services per person demanded in urban areas and the small number demanded in rural places, some strikingly different estimates are revealed: In Georgia, for instance, a patient load of 125 a week is obtained when the population figure is between 1,900 and 2,000 per physician; in Maryland, when it is 1,190 per physician; and in the District of Columbia and Baltimore, when it is a little under the 900 mark.

Summing up these estimates, the PHS says that to maintain the present quality and volume of medical care, Baltimore and Washington should have one physician for each 900-1,100 persons; Maryland needs one for each 1,200-1,500; Georgia needs one for each 2,000-2,400.

In all areas, as might be expected, general practitioners in the 35-44 age group have the highest average weekly patient load. These physicians, moreover, see more office patients per hour than those of other age groups. The patient-load average starts to decrease with the 45-year-olds, and goes down as the years go up. [*Continued on page* 128]



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Your Office as Others See It

Nationwide poll made for this magazine reveals patients' likes and dislikes

It goes without saying that you want to put your patients at ease while they're in your office. But how to arrange things to please the majority? What features do people find desirable in a physician's quarters? Which ones do they dislike?

To get the answers to these and other questions,* MEDICAL ECONOMICS, in September, commissioned Fact Finders Associates, Inc., New York research organization, to make a nationwide sampling of public opinion. All replies were secured through personal interviews. They came from a cross section of Americans, diversified by age, sex, location, income, and occupation. The respondents live in urban and rural areas of twelve states.†

Two questions asked were: "What do you like about your doctor's office? What do you dislike about it?"

Tabulation of the replies revealed that those questioned *liked* more things than they *disliked*. Of course, since they had been invited both to praise and to damn, many split their tickets. But in the aggregate, 79 per cent of the comments concerned features people liked, while only 21 per cent were about things they disliked. (Incidentally, 7 per cent of those interviewed said testily that they *liked nothing* about their doctors' offices, but 59 per cent said they *disliked nothing*.)

The accompanying table illustrates graphically the general things patients want in a physician's office. It was made from a compilation of all responses to the above two questions.

What of specific likes and dislikes? The respondents mentioned quite a few. Some condemned ugly furniture and depressing paintings. Others asked for plants, fresh flowers, and bright water colors. A Wisconsin factory superintendent said his doctor's office gave him "a feeling of impending doom." Hard, uncomfortable chairs came in for an equally hard panning. A New Jersey resident objected to "heavy drapes and overstuffed furniture which harbor germs." A Savannah, Ga., housewife liked her doctor's office because it contained "delight-

*Response to the other questions will be reported in early issues.

†California, Georgia, Indiana, Iowa, Kentucky, New Jersey, Pennsylvania, Ohio, Oregon, Texas, Washington, and Wisconsin.

ful playthings to amuse the children while they wait."

As could have been predicted, there was some caustic comment on old, dog-eared magazines. People told the interviewers they liked a *variety* of *good, up-to-date* periodicals—specifying that they did *not* want medical journals.

Plenty of modern equipment and apparatus was an indication, many thought, of a progressive doctor. Lack of it, some said, tended to destroy their confidence.

Adequate ventilation was stressed by a number of respondents, some of whom objected to the odor of medicines and antiseptics. A few people resented having to stand while waiting in the reception room. Some deplored having to wait at all.

Two Des Moines, Iowa, housewives objected to the fact that the reception room in their physician's office had no outside windows. A Philadelphia gardener considered himself insulted by a sign that said: "Please don't take books or magazines away from this office." A housewife in the same city shuddered at the sight of instruments: "I don't like to see them in full view when I walk in," she declared.

A Newark, N.J., architect remarked that his doctor's office, situated on the second floor of a building in a busy section, was "bombarded by traffic noise."

Surprisingly enough, a few features that are generally regarded as quite desirable in a physician's office were not mentioned at all. For instance: a separate exit from the consultation room, permitting patients to leave without going through the waiting room.

WHAT PATIENTS WANT IN A DOCTOR'S OFFICE

(Figures represent percentages of total comments made by persons interviewed in a survey for MEDICAL ECONOMICS)

Neatness and cleanliness	20
Attractive furnishings and decoration	15
Comfort	14
Ample space to avert crowding	10
Cheerfulness and pleasantness	8
Modern medical equipment	8
Enough good, recent magazines	7
Accessible location	6
Good ventilation	6
Adequate light	2
Miscellaneous	4
	100

How Osler Made His Mark

Random highlights that help to explain a notable career

Some have said that Sir William Osler's innate love for humankind was the key to his success. Others have attributed it to his unusual powers of observation or to his outstanding abilities as a teacher. Actually, the author of the great textbook, "The Principles and Practice of Medicine," cannot so easily be explained. He was simple yet complex; a diamond of brilliance, depth, and clarity—and of infinite facets.

° ° °

Osler treasured his friends, even when demands on his time became heavy. He was never too busy to keep in touch with them. While still in his teens, he developed the habit of dashing off messages to former classmates; and all through life he made it a point to remember birthdays and anniversaries. When pressed for time (he was forty before he enjoyed the luxury of a secretary) he resorted to the use of penny postcards to send some snatch of news or word of cheer to a former neighbor or fellow physician. Later, when he was famous himself, he delighted in arranging testimonial dinners for his friends.

As a student at Toronto Medical School (*circa* 1870), Osler decided that hard work was the vital ingredient of success in medicine. (He was only twenty-one at the time.) "Though it may be well for a physician to have outside interests, it is dangerous to let them become too absorbing,"* he once said. In later years he played golf occasionally, but it never became an out-and-out hobby. The only avocation he ever recommended to his medical students was book collecting.

° ° °

In addition to work, Sir William maintained that a doctor needed four characteristics: "The Art of Detachment, the Virtue of Method, the Quality of Thoroughness, and the Grace of Humility." He might have added a talent which he himself used: the gift of the peacemaker. His genius for settling differences became an effective antidote for much professional jealousy.

Punctual in all things to a remarkable degree and a great believer in brevity, Osler often said

*This and subsequent quoted passages from Harvey Cushing's "The Life of Sir William Osler." By permission of the Oxford University Press, New York.

COLLOIDAL IRON *VS* IONIZABLE IRON

In the CHLOROSIS YEARS

WHILE the incidence of frank chlorosis is today much lower than in former years, there is nevertheless a decided tendency for adolescent growing girls to develop a characteristic clinical triumvirate —anemia, malnutrition and digestive malfunction. In combating this syndrome, colloidal iron-protein has major therapeutic advantages over the iron salts. The salts (sulphates, citrates, etc.) are split up in the stomach with release of ions likely to be astringent and irritating. In the intestine, such ions form inert precipitates which are dehydrating, constipating and difficult to assimilate.

But the iron in OVOFERRIN is *colloidal* iron-protein. It is not in ionic form. It is little affected by the gastric juice. It is stable and cannot irritate. It arrives in the intestine as a fully hydrated colloidal oxide which cannot constipate and is readily assimilable. It is noteworthy that *most* nutriment is absorbed in colloidal form.

Not only is OVOFERRIN a rapid blood-builder, free from irritating and constipating effects, but it appears to have a decided propensity for appetite stimulation. Important also in insuring patient cooperation in these finicky young ladies is the fact that it is tasteless and odorless and that it cannot stain or dissolve tooth enamel. But it achieves these effects, not by coating or sweetening or masking, but by the simple inherent fact of its colloidal form. Dosage—one tablespoonful in a little milk or water at meals and bedtime.

PRESCRIBE **OVOFERRIN**

COLLOIDAL IRON-PROTEIN BLOOD-BUILDER

In Secondary Anemia, Convalescence, Pregnancy, "The Pale Child," and Run Down States

A. C. BARNES COMPANY

NEW BRUNSWICK, N. J.

that with these two traits a physician might well achieve success even when more important ones were missing.

* * *

Constantly Osler emphasized the importance of regular attendance at medical society meetings—and was himself the perfect model in this respect. Whether the gathering was small or large, he was always on hand promptly, and he took a lively part in all discussions. Rarely did he refuse to do the many thankless tasks that go with committee work; and continually he helped to organize new associations and revivify old ones whose members had allowed their interest to wane.

* * *

Wherever he went, Osler sought out the company of older doctors. In Canada, in this country, and abroad, they were the ones with whom he preferred to mingle.

* * *

He was a lover of literature, with an unusual knowledge of the classics, poetry as well as prose. As the years went by, his own library grew steadily, and he never ceased to urge his students to cultivate good reading. In his last years, Sir William found great solace in the works that he had spent a lifetime collecting.

* * *

"Observe, record, and publish!" Again and again he urged that precept on his students. It was this search for facts—facts of the microscope, the bedside, and the post-mortem room—that he declared to be the foundation for progress in medicine. "Use your senses. Learn to see, hear, feel, smell. But see first. The whole art of medicine is in observation. Don't touch the patient—state first what you see. See—then reason and compare. Medicine is learned at the bedside, not in the classroom. Live in the ward. Don't waste the hours of daylight in listening to that which you may read at night. But when you have seen, read. Record that which you have seen; make a note at the time; don't wait."

* * *

All his life, Osler made a practice of taking notes. Virtually everything he did became grist for his literary mill. He jotted down memos in hospital wards, on trains, and at medical society meetings—even keeping records of his own maladies. He delighted in calling himself "the notebook man."

* * *

That passion for accurate observation and notation was evident in his early career. He was a professor of pathology when a severe smallpox epidemic broke out in Montreal in 1875. Osler assumed charge of the smallpox ward at the Montreal General, at the same time continuing his lectures at McGill. This was his first chance at ward responsibility. Gathering all possible data from his clinical observations and post-mortem reports, Osler pre-

pared five papers on various aspects of smallpox. He first proved his worth as a hospital attendant; then his papers brought the twenty-six-year-old physician to the attention of the profession throughout Canada and the United States. (The extra salary, enabled him to procure much-needed microscopes for his pathological laboratory.)

• • •

During this epidemic, Osler met a young Englishman who was in Montreal on business. While dining with him one evening, Osler noticed that the young man appeared ill. He diagnosed the symptoms as those of smallpox and hospitalized his new friend. Unfortunately the disease proved fatal within three days. Impelled by pity Dr. Osler wrote an informative and genuinely sympathetic letter to the young man's parents three thousand miles away. Thirty years later, after he had become Regius Professor of Medicine at Oxford, Dr. Osler paid a visit to his dead friend's aged mother, taking with him a photograph of her son's grave in Canada, which he had gone to some trouble to obtain for her.

• • •

Busy as he was with the 1875 epidemic, Osler managed a hurried trip to Boston, whose medical traditions he was eager to investigate. There he formed several new friendships that stood him in good stead years later—and spent every minute he could spare browsing in the medical library. Countless hours of his life, in fact, were to be spent in the medical libraries of Europe and America—especially during his "brain-dusting" expeditions. (To him, refresher courses every five years were a vital need of the profession; and the very cornerstone of his philosophy was the axiom that the physician must never cease to be a student of medicine.)

• • •

That Osler was a glutton for work is evidenced by the fact that in a single twelvemonth (1876-77) he compiled from his pathological notes three large quarto volumes in which 100 autopsies were worked up in detail in his own hand, properly numbered and indexed. Later, printed in book form, they won him considerable recognition—being the first such report ever published on this continent. Incidentally, he always laid great stress on the careful investigation of the causes of death, and made it a practice to correlate post-mortem facts with clinical histories and notes taken in the wards.

• • •

Even his skepticism was constructive. Once, on learning that a French army surgeon was reputed to have discovered certain pigmented bodies in the blood cells of malaria victims, he immediately set to work to verify or disprove the report. Not until he had spent several months investigating some seventy cases

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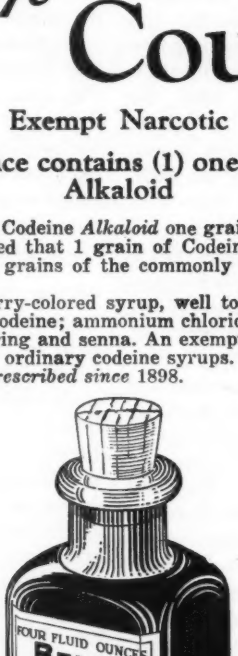

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was he convinced of its truth. Subsequently, a paper detailing the results of his studies put him in the front rank of investigators of malaria.

• • •

By the time he was forty-one, Osler was admirably fitted to undertake the writing of his monumental textbook. His long apprenticeship in pathology, together with his clinical work in Montreal, Philadelphia, and at Johns Hopkins in Baltimore (he played an important part in organizing that great institution), had given him a wide experience and a broad viewpoint. Moreover, he understood thoroughly the make-up of a sound physician. "The student-practitioner requires three things to stimulate and maintain his education: a notebook, a library, and a quinquennial brain-dusting . . . Never ask a new patient a question without notebook and pencil in hand . . . Begin early to make a three-fold category: clear cases, doubtful cases, mistakes . . . For the general practitioner, a well-used library is one of the few correctives of the premature senility which is so apt to overtake him . . . It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it."

• • •

Osler was open-minded, patient, and tolerant. Conservative in the use of drugs, he was never overantagonistic to dosing; and while he considered that specialization limited a man's medical knowledge, he clearly recognized its advantages in certain fields. (Incidentally, it was only on the advice of one of his early teachers that he abandoned a youthful ambition to become an ophthalmic surgeon.) He was far more tolerant of surgery than most of the doctors of his day, and seemed to sense the proper moment for its use. Likewise, he had a marked tolerance for those who believed in faith cures, holding that faith is an asset to the physician. And though he would have nothing to do with psychoanalysis as such, he always worked for harmony and better understanding among all branches of the profession.

• • •

Osler put a high value on constructive criticism. He maintained that the busy general practitioner tends to become egotistic, and that a good, effective antidote is exposure to the influence of medical society meetings and the give-and-take of open discussion. Osler firmly believed that the G.P. was the very heart and soul of the profession—the standard by which all are measured. He warned continually against the early inroads of senility, urging older practitioners—those above forty—to "keep in contact with fresh young minds," and to grasp every opportunity for post-graduate study.

—FRANK T. MOORE

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WELCH GRAPE JUICE COMPANY, Westfield, New York

Oil—Domestic and Foreign

Market prospects of the production and refining companies

Despite the controversial aspects of federal policies affecting the petroleum industry, certain basic economic forces are at work which it seems to us must eventually benefit favorably situated oil equities. These economic forces are (1) record consumption of petroleum products and (2) declining supplies of crude oil in the United States.

The Petroleum Industry War Council has issued estimates indicating that the shortage of domestic crude will amount to 200,000 barrels daily early in 1944 and will increase to more than 500,000 barrels daily late in that year if the war continues. There have been many conflicting statements in the press regarding the petroleum situation, caused mainly by disagreements over federal policies, but the changing supply outlook cannot be denied.

Demand and supply of crude oil in the United States have long been out of balance. Demand has exceeded supply for many years and the nation has been dipping into above-ground stocks in order to meet full requirements. Before Pearl Harbor, we imported substantial quantities of oil from South America. These imports were largely cut off for more than a year, causing a further disparity between domestic demand and supply.

Domestic oil rationing has cut over-all petroleum requirements this year but not enough to reduce demand below the level of supply. War needs have been far greater than expected and may rise further. In Texas, for instance, federal agencies buy 50 per cent of all gasoline sold in the state. Demand there is greater than ever before in history. In the Eastern States, however, consumption has been cut materially.

The accompanying table shows a 103,000,000-barrel slice taken out of oil supplies in the United States during the 10½-year period up to July 1, 1943. This was in spite of the steady increase in output, which in recent years has been running at all-time peak

¶ Prepared by the research staff of a leading New York Stock Exchange house, this report gives the investor a clear cut, over-all view of the domestic and foreign industry—including its post-war outlook.

MOST URINARY TRACT INFECTIONS YIELD TO

SULAMYD

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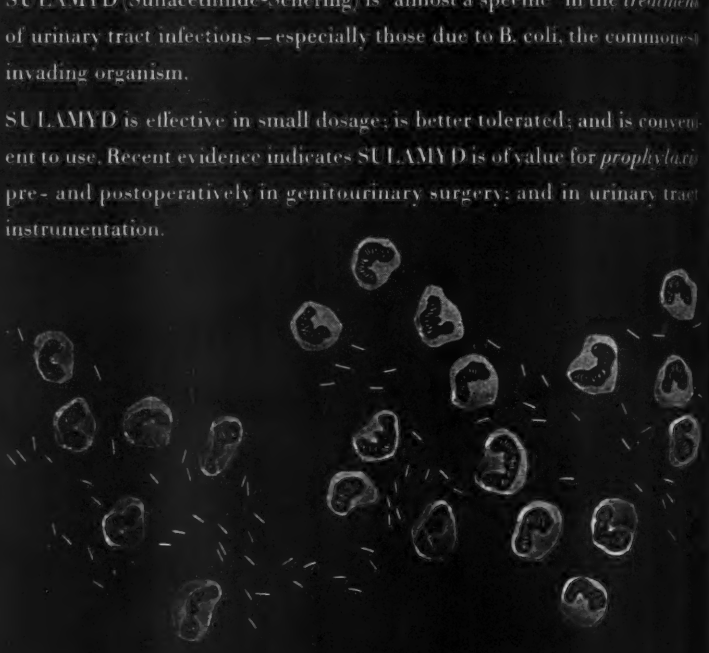

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levels. Even more important is the fact that the excess of consumption over output is expected to widen rather than decrease.

Crude oil production engineers are convinced that domestic output has about reached the limit possible within sound engineering practice, except for the West Texas area where many fields are yielding substantially less than could be produced. Output beyond sound production principles, so loudly decried by the Petroleum Administration before Pearl Harbor, results in reduced ultimate recovery of oil from the sands and is therefore wasteful. Moreover, it would serve to hasten an acute shortage of oil for war and other essential uses. Large prospective demands, therefore, can be met without wasteful production only by a reversal of the declining discovery trend of recent years or, as is more likely, by the importation of larger quantities of crude.

That the post-war world in general will turn to oil on an unprecedented scale appears certain. Not only past and present automobile owners but many new ones will want to drive cars. Tens of thousands of youths who have practically lived in airplanes as part of their military service will welcome the opportunity to use them for pleasure. Commercial air transportation will in all probability be at a new high.

The growing shortage of Amer-

THE DEFICIT IN OIL
(Millions of Barrels)

	Demand (Domestic and Export)	**Supply (Domestic and Imports)*	*Stocks All Oils End of Period*	*Net Withdrawals from Storage*
*1943	680	672	489	8
(1st 6 mos.)	1,538	1,480	497	58
1942	1,505	1,496	555	9
1941	1,456	1,495	564	**39
1940	1,408	1,378	525	30
1939	1,330	1,321	555	9
1938	1,343	1,388	564	**45
1937	1,224	1,202	519	22
1936	1,113	1,090	541	23
1935	1,035	996	564	39
1934	975	986	603	**11
1933	13,607	13,504	...	103

*Estimated
**Additions to storage

At the end of 4 to 6 hours Sal Hepatica solution mounted almost to top of thistle tube from low level (see inset).

In Vitro and in Vivo

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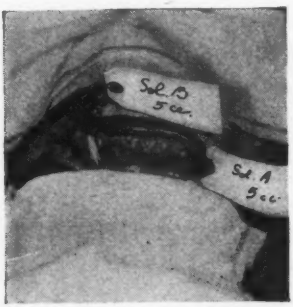
IN glass and in the ileal loop of a laboratory animal Sal Hepatica demonstrates the reason it has become the efficient saline laxative recommended by medical men everywhere—the ability to create *liquid bulk.*

Sal Hepatica in laxative solution was placed in a dog's isolated ileal loop. An hour later examination revealed that the solution had gained 34 per cent in volume. A laxative solution of Sal Hepatica placed in a thistle tube sealed tight with a semi-permeable membrane and suspended in Ringer's solution gained approximately 34 per cent in volume within two hours —and about 100 per cent in 6 to 12 hours.

When gentle yet thorough laxative action is needed for patients, physicians everywhere naturally turn to Sal Hepatica.



Sal Hepatica in laxative solution increased 34 per cent within one hour in an isolated loop of a dog's ileum.

SAL HEPATICA

SUPPLIES LIQUID BULK TO FLUSH THE INTESTINAL TRACT

Bristol-Myers Company, 19-11 West 50th St., New York 20, N. Y.

ican crude oil in the face of increasing petroleum requirements points to the possibility that the United States may never again be able to supply its own needs, let alone ship large quantities abroad as in the past. Petroleum Administrator Ickes has stated that this country may well become an oil importing nation. The Secretary even cites the possibility of having to produce oil from coal, a high cost process at best.

So immediate is the prospect of this change in the position of the United States that plans already are under way, it is understood, to increase crude oil production and refinery capacity in Venezuela, Colombia, the Near East, and Canada next year. The largest proportion of this increase will probably take place in Venezuela. Major expansion of foreign oil fields is also anticipated in the post-war reconstruction period due to growing world requirements.

It is of special interest to note that foreign oil reserves are held by a relatively few oil companies. An expansion of foreign output would obviously have an important effect on prospects of these units.

A number of factors in the post-war outlook are of course more sobering in character and must not be overlooked. These include the following:

1. Probable continuance of some degree of federal control of petroleum operations. This may be necessary until a decision can be rendered as to (a) the disposition of substantial government controlled facilities such as pipelines and (b) the policy regarding price control and subsidies. These features of government control are not likely to be dropped automatically with the declaration of peace.

2. The general financial situation and its effect on consumer buying power, including the status of taxation.

3. Availability of facilities for peacetime use of oil. The quantity of motor cars available for civilian use will depend on the length of the war. Based on wartime production schedules, the longer the war, the smaller will be the volume of efficient automobiles, airplanes, oil burners, etc., for public use when peace comes.

Out of the foregoing considerations it may be somewhat difficult to evolve a clear analysis of post-war prospects for the petroleum industry. Nevertheless, it is more simple in the case of other major industries.

The oil industry has had no labor problem to speak of and can utilize its own facilities for transportation and retail sale. Available transport facilities, represented by pipelines, tank steamers, and river barges, will be the most extensive in the history of the industry. Therefore, petroleum products should be available for every need in every part of the world.

There is, in our opinion, a

near-term possibility of a general crude oil price rise here and in foreign fields. While not wishing to add to the controversy of the petroleum industry and Petroleum Administration for War, versus the Office of Price Administration, as to whether or not a crude oil price rise is merited at this time, we wish to express our belief that a point will be reached eventually, if present demand and supply trends continue, when the shortage of oil will become so acute that any verbal controversy to support higher prices will seem superfluous.

In the light of present conditions, further general improvement in the petroleum situation and in the position of the securities of the well-established oil producing, refining, and marketing companies appears highly probable. It is of course essential for investors to use discrimination in order to obtain participation in those issues able to improve their position in the face of reduced crude oil supplies and federal restriction that apply to all branches of the oil business.

While a crude oil shortage is developing in the United States, large quantities of foreign oil in the post-war period are assured from South America, particularly Venezuela and Colombia, and from the Near East, Iran, Iraq, Kuwait, Saudi Arabia, and Bahrein Island. A goal of more than 1,000,000 barrels per day has been set for South American production before the end of 1944, compared with about 600,000 barrels at present, it is reported.

Participation in foreign oil expansion narrows down to relatively few companies when compared with operations in the United States. Standard Oil of New Jersey, for instance, produces less than 10 per cent of the total daily crude oil production in the United States but will probably account for 50 per cent of the expanding output of Venezuela.

The Shell organization, responsible for perhaps 3 per cent of U.S. production, will have 20 to 30 per cent of that of Venezuela, it is estimated. This means that certain oil companies that control foreign crude oil production and reserves may be in a position to show unusual earnings expansion not only in the near future but also during the post-war period; especially so in the latter period because there will probably be no restriction abroad on consumption or on refinery construction. At present, foreign crude oil output, especially in the Near East, is restricted by limited refining facilities.

Another factor in favor of the Venezuelan, Colombian, and Near East fields is their demonstrated productivity and big reserves of oil believed to exist there. Estimates indicate that combined reserves in these areas may total 30,000,000,000 barrels, or 50 per cent more than are estimated to exist at present in the United States.

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The examples printed at the right are intended merely as guideposts. Make your contributions as lively, illuminating and unusual as you can. If they are amusing, so much the better. Should no illustrative anecdote occur to you, a clear, concise description of some helpful psychological technique used in treating patients may be acceptable.

Contributions must be typewritten and cannot be acknowledged or returned. Maximum length 300 words, but the shorter the better. Address "Human Nature Editor," The Reader's Digest, Pleasantville, N. Y., before January 3, 1944.

Dr. Weir Mitchell had no sympathy with patients whose ailments were largely imaginary and who were never happy unless under treatment by a fashionable physician. There was the famous story of the woman who refused to get out of bed. Dr. Mitchell had run the gamut of argument and persuasion and finally announced: "If you are not out of bed in five minutes—I'll get into it with you!" He thereupon started to remove his coat, his patient still obstinately prone; he removed his vest; but when he started to take off his trousers—she was out of bed in a fury!

—ANNA ROBESON BURR, *Weir Mitchell, His Life and Letters* (Duffield)

One busy doctor took into his garden patients who didn't quite know what was the matter with them, so that the sight of his roses might do what medicine could not. He prescribed, along with camomile and other medicaments, a dozen Hybrid Teas. To those who could not afford his medicine he gave slips, with instructions for rooting them, or even whole bushes.

I rode around to see some of this doctor's patients. "This man," he'd say, as we drove through a factory gate, "thought he had chronic dyspepsia," and then we would see how this engineer had masked with climbers the walls and fences of his boiler house and rimmed the place with beds of roses. Another patient, a woman, had completely forgotten what was the matter with her by restoring an old garden.

—RICHARDSON WRIGHT in *The Gardener's Day Book* (Lippincott)

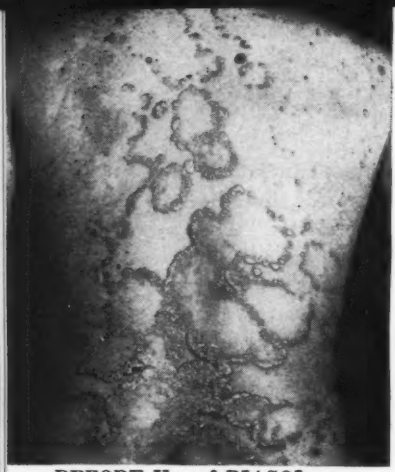
The late Dr. Luther Emmett Holt, the great baby specialist, had a standard treatment for frail newborn babies who failed to gain weight. When he came to the chart of such an infant during his hospital rounds, he always wrote the following direction for the nurses:

"This baby to be loved every three hours."

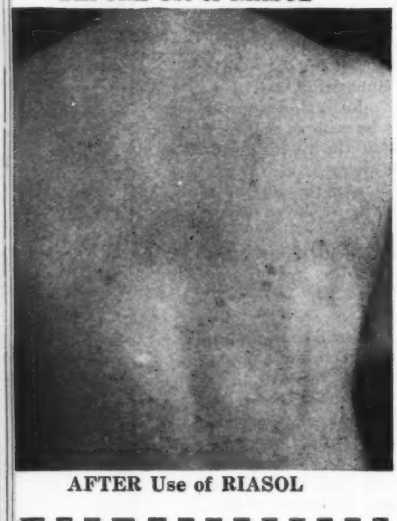
—JOSEPHINE H. KENYON, *Healthy Babies Are Happy Babies* (Little, Brown)

I have always made it a point, when dealing with children, not to be connected in any way with their pains. They are much easier to handle then. If I have to perform an operation on a child, I never appear before him in surgical costume. I show up after he has been put to sleep and disappear before he is awake; and at my first call he invariably informs me that he didn't like the man in white clothes (my assistant) because he hurt him.

—DR. JOSEPH A. JERGER in *Doctor—Here's Your Hat* (Prentice-Hall, Inc.)



BEFORE Use of RIASOL



AFTER Use of RIASOL

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RIASOL FOR PSORIASIS

XUM

Lawsuits Often Result of Failure to X-Ray

Incorrect diagnoses, resulting from this neglect, may be actionable

The physician makes his diagnosis and decides upon treatment after he has gathered certain facts about the patient's condition. If he fails to gather those facts properly (*e.g.*, does not employ certain indicated diagnostic procedures) he may become liable for malpractice.

Ordinarily the public is not familiar with, or particularly interested in, the procedures a doctor employs to arrive at a diagnosis. But X-rays are on exception; the average layman feels he has more than a passing knowledge of them. In fact, many a physician has been irritated by the demands of a patient to be X-rayed even after it has been pointed out that such examination could reveal nothing helpful.

This pseudo-familiarity of patients—and lawyers—with roentgenography increases the possibility of a suit if the physician fails to X-ray. Thus he cannot always safely base his judgment as to the desirability of X-ray examination on medical reasoning alone. He must remember that should his diagnosis be erroneous or incomplete, he may pay heavily for his failure to have used this aid.

Under ordinary circumstances, when an X-ray would merely confirm a diagnosis established by other clinical evidence, it may be dispensed with; for then the physician could not successfully be charged with negligence in omitting it.

And this is especially true if local medical opinion is divided on the wisdom of X-raying a particular type of condition; for, under the circumstances, if the physician employs one of several accepted methods, he can scarcely be called negligent.

Conversely, if a plaintiff can show that most physicians in the community *usually* X-ray in such cases and that his doctor did not, he will have bettered his chance of recovering damages.

Here are some typical cases:

A tailor ran a needle into his thumb; it broke off and a fragment remained in the wound. His physician attempted to remove the fragment by incision and probing, but was unsuccessful. He then advised the patient to return on Monday morning (the acci-

dent occurred on a Saturday afternoon) to be X-rayed.

Saturday evening, however, the thumb and hand became swollen, and he developed a fever. He was unable to reach his doctor that night or on Sunday. On Monday morning, another physician ordered him to a hospital, where an X-ray disclosed the position of the fragment. It was removed, but the infection became worse, making amputation of the thumb necessary.

The tailor sued the first doctor, claiming that his failure to X-ray immediately was responsible for the amputation. Returning a verdict for the plaintiff, the court stated that it is common knowledge that a needle fragment can cause infection; that an X-ray was indicated; and that the defendant should have taken one immediately.

Another case concerns a physician who did an open reduction of a fractured ankle in 1930, using a metal screw. In 1937 his patient returned, complaining of pain in the ankle. The physician diagnosed the condition as arthritis, and treated it as such. When the pain continued, the patient went to another doctor in 1938. This practitioner X-rayed and found necrosis of the bone around the screw. The screw was removed and the patient recovered. He thereupon instituted suit against the first physician for failure to X-ray in 1937.

In court it was shown that there was no evidence, other than that of the defendant physician, proving that either arthritis or necrosis existed in 1937. The second physician, naturally, could testify only to what he had found in 1938.

Cross-examined, he admitted that if he had seen the patient in 1937 he, too, might have diagnosed the case as arthritis, perhaps not have X-rayed. The court ruled that while X-rays offer the best method of diagnosing changes in the skeletal structure, failure to X-ray in all cases does not prove a departure from standard medical practice. Verdict was returned for the defendant physician.

But it should be noted par-

To Prevent Muscular Wasting

during illnesses in which there is an inadequate protein intake, modern therapy prescribes regular intravenous injections of parenteral

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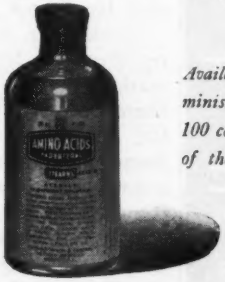

Available for parenteral and oral administration as a 15% solution in 100 cc. rubber-capped vials. Details of therapy available on request.

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SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

enthetically that had another physician seen the patient *in 1937*, and testified at the trial that under accepted standards of practice an X-ray was indicated, the defendant might have been found guilty of negligence.

In the preceding cases, the doctors were charged with negligence for not X-raying at the *beginning* of their treatments. It is possible that a physician who does X-ray at the outset, but who neglects to follow up original X-rays with another series, may also become liable for damages for malpractice. For example:

A man sustained a fracture of the forearm. His doctor immediately exposed several X-rays and found the bone fragments in poor position. He then reduced the fracture and placed the arm in a cast. He did not X-ray again.

Weeks later, when the cast was removed, the forearm showed a marked deformity. The patient thereupon consulted another doctor, who X-rayed the arm and found the bone fragments in poor position, accounting for the deformity. He rebroke the bones and reset them, and eventually a good positioning of the fragments was obtained.

The patient sued the first doctor for failure to take X-rays when the cast was applied. Following medical testimony that proper practice called for a second X-ray immediately after a fracture had been reduced, a verdict was returned against the defendant.

—JAMES R. ROSEN, M.D., LL.M.

'My Most Interesting Experience'

Skull and dagger... Phantom fetus
Glutches... Double-decker donor

As an interne, I was called upon to give blood for a transfusion. The surgeon, I knew, always used the direct, multiple-syringe method. However, this time after I had been cross-matched, I was called to the laboratory by a new technician unfamiliar with the surgeon's preference. Despite my protests, he drew a pint of my blood into a bottle of citrate, and rushed off with it to the operating room.

Just as I was leaving the laboratory he returned in dismay, having learned of the surgeon's unyielding aversion to citrated blood. There was no time to match a new donor so we ran to the operating room where another pint of my blood was drawn and injected into the patient by the multiple-syringe method.

The patient responded nicely, but it was necessary to wheel *me* back to the laboratory for a transfusion of citrated blood—my own!

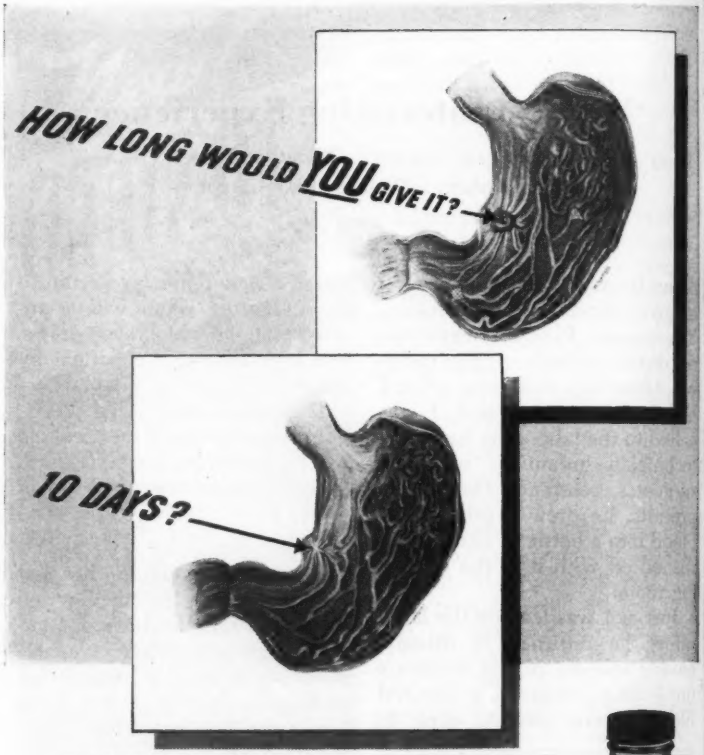
—M.D., OHIO

There's a dagger in the anatomical museum of the London Hospital (Mile End Road, London, England) with a rather remarkable history—a history that perhaps I can recount best, since I was the first physician to see the weapon.

One midnight, while I was on duty at the hospital as admitting officer, a young man walked into my office. His costume almost struck me dumb; for while he was dressed in ill-fitting, workingman's clothing, he was also wearing a tall, stylish silk hat. He was perfectly sober but evidently in a great deal of pain.

Almost immediately the youth launched into his story: It seemed that he had been jilted by his girl, and the shock was so great that he had no desire to continue living.

¶Readers suggested this department through which physicians might tell each other about the most amusing, exciting, embarrassing, or amazing incidents that had occurred in their practices. Willing to help stimulate interest in the idea, MEDICAL ECONOMICS agreed to pay $5-$10 for each acceptable description of such an experience, with the understanding that contributors could remain anonymous. The ancedotes published herewith were among the first to arrive. You are invited to submit yours.



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**WOLDMAN, E. E. and POLAN, C. G.: The Value of Colloidal Aluminum Hydroxide in the Treatment of Peptic Ulcer; A review of 407 Consecutive Cases, Am. J. M. Sc. 198: 155-164 (Aug.) 1939

AMPHOJEL* *Wyeth's* **ALUMINA GEL**

REG. U. S. PAT. OFF.

He went, therefore, to an attic room in his boarding house and drank a quantity of antiseptic. The only result was violent nausea, which made his condition even more wretched. He then took a rope, threw it around a ceiling beam, and tried to hang himself. But the rope broke.

Desperate, by this time, he got a short, strong dagger and a mallet. Holding the dagger with its point against the top of his head he struck it a hard, downward blow. Since he did not drop dead as he had expected, he hit the dagger again, and again. But still he remained alive and upright.

Now, to add to his other troubles, he developed an intense headache. To relieve it, he tried withdrawing the dagger from his skull, but it was much too firmly imbedded.

What to do next? The hospital was not far away but he could hardly walk to it with the dagger sticking out of his skull. He solved the problem by "borrowing" a tall silk hat. With this on his head to conceal the dagger, he arrived in my office.

I removed the hat and, sure enough, there was the dagger as he had described it. Since I could not remove it in the outpatient department, I had the man taken to an operating room, where the weapon was soon withdrawn.

About two inches of its strong blade had entered the youth's skull and brain, probably in the superior longitudinal sinus. The passage of the blade through the scalp had probably cleansed it of organisms for no infection resulted. After a few days the would-be suicide was released from the hospital, none the worse for his adventure, except for a slight headache.

—M.D., MASS.

The family of the Mexican girl assured me, when I arrived at 3 A.M., that she had had the great misfortune of aborting. As evidence, they presented a pan containing a large placenta, a well-developed cord, and sundry blood clots.

While I was inspecting these by the feeble light of a decrepit oil lamp, some one happened to open an outer door. With loud yowls, two cats, wild with hunger, dashed into the room and clawed their way up my legs, evidently making for what I had in the pan. When we had managed to get rid of the intruders, I asked the old people if I might see the fetus. Alas, they protested, there was none . . . Quite evidently a miracle, senor.

Ordinarily, a pelvic examination would be unthinkable, but I had to account somehow for the missing star of our little drama. With such precautions for asepsis as could be achieved under the circumstances, therefore, I made my examination. It revealed a firm perineum, a pinhole os, and a fundus of virginal dimensions.

It was then that I decided to get rid of the family and have a talk with the girl.

She was quite frank. Not long

a bride, she had delighted her husband with the news that a blessed event was impending. A little later she discovered that there had been a mistake. Rather than cause her spouse disappointment, she sought some other way out.

A pig's liver served as a placenta. A hole punched in the concave surface offered a point of attachment for a "cord" of pig's intestine. A few scraps of lung tissue passed for blood clots in the dim light of the smoky oil lamp.

The cats, of course, had known liver when they smelled it. But they would never tell. And since the doctor held his tongue too, the patient "recovered" and life in the shack went on as before, marred only by one insignificant miracle. —M.D., CALIF.

It happened last summer in the humble shack of a fisherman whose wife was apparently very ill. When I inquired about her trouble, she replied:

"Doctor, I's burning like hellfire, and I's got the most beautiful pain in my clink horn—and it hurts me something terrible when I glutches."

I overcame my bewilderment at where to start my examination by asking the patient to point to the afflicted part. She did, and I discovered a truly "beautiful" infection of the larynx and surrounding tissues. —M.D., N.Y.

Licensure Boards to Accept Nine-Month Interneship

Several will require supplementary training in military hospitals

The recently announced 1944 interneship program of the Procurement and Assignment Service, which will curtail the training period in civilian hospitals from twelve months to nine, is not expected to result in serious licensure snags in any of the states or territories. At least this is the conclusion drawn from a survey conducted for the P&AS by the Federation of State Medical Boards.

At the same time the survey disclosed that the nine-month system is not being greeted with universal enthusiasm. Some state boards declared that they would accept it for the duration only; others qualified their acceptance by demanding that the internes concerned be given an additional three month's training in Army or Navy hospitals.

The federation sent out two sets of questions:

1. One went to the boards of examination and registration in twenty-two states*, the District of Columbia, Alaska, Puerto Rico, and Hawaii, each of which requires a twelve-month interneship as a prerequisite to licensing.

2. The second was sent to the boards of the remaining twenty-six states, which do not require interneships.

The first group was asked three questions:

"1. Will your board approve a decrease in the hospital interneship from twelve to nine months for the duration of the war?

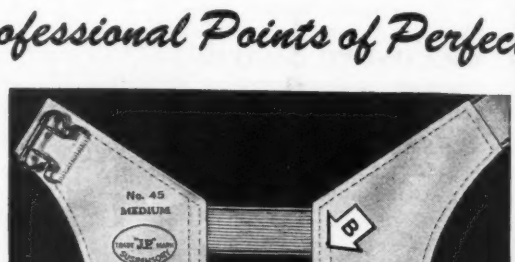
"2. Will your board accept subsequent service in the armed forces from those physicians who leave their interneship at the end of nine months, at such time as they may apply for license in your state?

"3. Will your board accept continued training in civilian hospitals from the ninth to the twelfth month from those physicians who are physically disqualified and therefore do not enter the armed forces?"

A letter accompanying the questionnaire pointed out that the new program had been approved by the Council on Medical Education and Hospitals of

*Alabama, Delaware, Idaho, Illinois, Iowa, Michigan, Montana, Nevada, New Hampshire, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

Professional Points of Perfection



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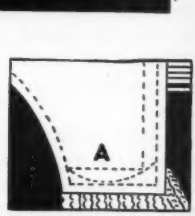

B. Double sewing along front of yoke gives extra strength.

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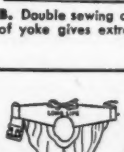


LONG LIFE 101 *Drawstring Type*

the American Medical Association.

Replies were received from all twenty-two states and from the territories, except Hawaii. Most boards assented to all three proposals. But a number said they would expect the nine-month internes to receive at least three additional months' training in a Navy or Army hospital. Other boards said they would require a statement, signed by a responsible medical officer, certifying that the license applicant had received such supplementary training in an approved military or naval hospital.

These conditions in their immediate effect, may necessitate a change of policy on the part of the government in assigning new medical officers to duty. In other words, nine-month internes may be sent to hospitals rather than assigned immediately to active field duty.

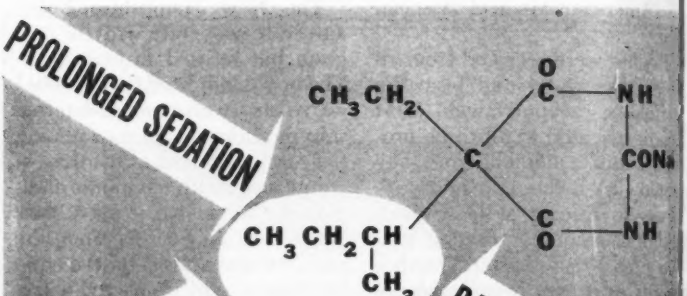
The states which demanded this supplementary training were New Jersey, Oregon, Utah, Washington, South Dakota, and the District of Columbia.

The New Hampshire board agreed to cooperate with the program but refused to endorse it. The board indicated that it would waive its twelve-month-internship requirement for men joining the armed forces, but that it would deal with each case individually rather than grant a blanket waiver. In Pennsylvania, the problem was solved by the state legislature, which enacted a law approving nine-month internships for the duration. In Oklahoma, where a twelve-month period is required by law, the state's attorney general ruled that the internship could be cut to nine months for the duration. Only two states, Illinois and Michigan, refused to approve the curtailed internships, but both are understood to have reconsidered, and it is expected that they will cooperate.

A different questionnaire was sent to the twenty-six states which do not ordinarily require internships. All replied that the shortened program would have no effect upon their licensing of physicians. —GEORGE B. FRITZ

"My Most Interesting Experience"

Readers suggested the department (see page 99) in which physicians may tell each other about the most amusing, exciting, embarrassing, or amazing incidents that have occurred in their practices. Willing to help stimulate interest in the idea, *Medical Economics* will pay $5-$10 for each acceptable description of such an experience. Contributors may remain anonymous if they so desire. Address your manuscript to Interesting Experience Editor, Medical Economics, Inc., Rutherford, N.J.



The deliberate inclusion of a secondary butyl group in the chemical structure of Butisol Sodium accounts for its rapid breakdown in the body.

The resultant effect is an intensification of the hypnotic potency, a reduced dosage, and a prompt recovery, without "hangover."

Prescribe Butisol Sodium in:

Insomnia	**Dysmenorrhea**
Labor sedation	**Spasticities**
Pre- and post-operative care	**Neuroses**

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UNWELCOME CONSULTATIONS

What to do about the doctor who habitually asks you to cut your fees for his patients

Just as some medical men have given their names to technical terms, there's a doctor in our town who's had a consultation named after him. But although McBurney's point and Bright's disease honor the physicians whose names they preserve, a "Jones consultation" is no tribute. In fact I doubt if Jones knows that the phrase exists, that, to his physician-colleagues, it means a consultation for a reduced fee.

Consultation chiselers, it's true, have always been with us. In almost every community of any size there have been a few doctors who, in calling upon a colleague for advice or aid, have invariably requested special consideration for their patients. (I am not, of course, referring to those who make this request occasionally and legitimately, but to those who make a habit of it.)

Today, it seems to me the number of these gentry is on the rise. The remarks of a young obstetrician I know indicate what the problem means to him:

"Last night was the fourth time it's happened in the last few weeks. Jones called from the hospital to ask me to come and help him out. As usual, he'd gotten involved in something he couldn't handle; and as usual the patient's husband was deserving but impoverished and must therefore be charged very lightly indeed.

"I delivered the child, but whether I'll get even $20 for it is uncertain. It's not impossible that Jones neglected to tell the father that he called me in. Each time this happens he gets me over a barrel because if I demur, he sounds shocked and says 'Fee or no fee, *somebody's* got to help this woman . . .' So I go."

The more experienced among us may smile a bit at my young friend's dilemma; to us a succinct dismissal of Jones would solve it neatly. Yet the matter is not quite so simple. It *could* be as wrong to dismiss Jones finally as to permit continued imposition.

While each of us must work out his individual answer, there are still some guideposts. For example:

Does the physician concerned repeatedly request special reduction for his patients, or does he ask the favor only occasionally? Does there seem to be a disparity between the frequency of his re-

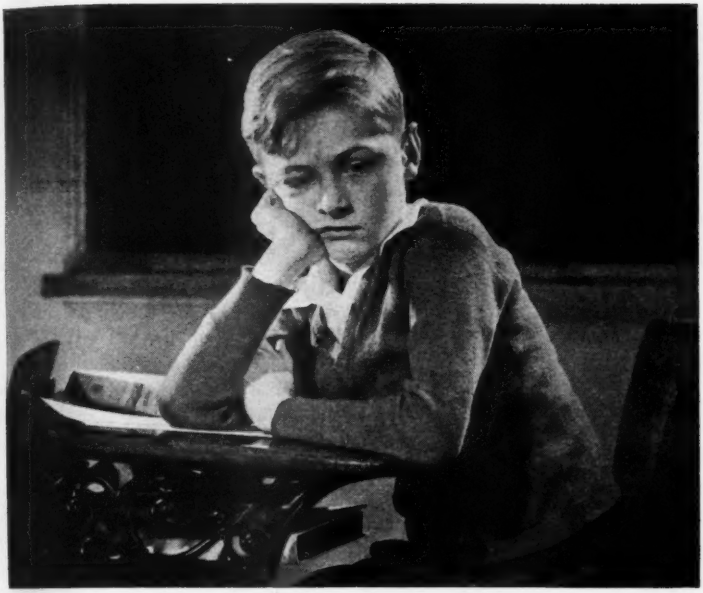
quests and his patients' general economic status? Are his calls for aid or advice often prompted by the fact that he has gotten out of his depth?

Sometimes one can test the sincerity of requests for reduced (or no) fees by merely saying, "Since this patient has had such hard luck, how would it be if we *both* overlooked the fee? Suppose we both just consider it a charity case?" Although the answer is often revealing, I don't recommend this as a routine measure, however, unless one has no qualms about giving offense.

There's a curious resemblance between consultation-chiseling and fee-splitting. The M.D. who regularly obtains a reduced fee for his patient does not of course receive the rebate which marks fee-splitting. But he does gain the patient's indebtedness, and perhaps precedence for his own bill.

In my opinion, one should go along with requests for reduced fees unless there are clear contraindications. Certainly one should help out a colleague in a spot—however he happens into it—when no other aid is open to him.

But—after tolerantly accepting two or three distinct impositions, I can see no sense in going further. A sturdily independent attitude, tempered as required by circumstance, will not just save time and money; it will also win professional respect—the kind of respect that the doctor who's always agreeably pliable never earns. —RICHARD MILLER, M.D.



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Faced with the case of *multiple* vitamin deficiency, you have a potent ally in IMPROVED Ol-Vitum Capsules.

Each capsule contains the following 8 vitamins—A, B_1, B_2, B_6, C, D, Niacin Amide and Pantothenic Acid. Each capsule supplies the following ratio to minimum daily requirements:

	Adults & Children over 12 yrs.	*Children 6 to 11 years incl.*
Vitamin A	125%	166%
Vitamin B_1	150%	200%
Vitamin B_2 (G)	100%	*
Vitamin C	100%	150%
Vitamin D	250%	250%

*Requirements not established

(The minimum daily requirements for Niacin Amide or the need in human nutrition for Vitamin B_6 or Pantothenic Acid has not been established.)

IMPROVED Ol-Vitum Capsules are a most convenient way to assure adequate vitamin intake inexpensively. They are a product of "The House of Vitamins"—of the International Vitamin Corporation, which specializes solely in the manufacture of vitamin products.

Twenty-eight I.V.C. vitamin products bear the seal of acceptance of the Council on Pharmacy and Chemistry of the A.M.A.

Improved
I.V.C. OL-VITUM
The "8-Vitamin" Capsule

Medical Service Council

[*Continued from page* 51]

ready been analyzed by the AMA Bureau of Medicine and Legislation, why was another analysis believed necessary?

Answer: The council thought the bill should be examined from a little different angle and felt that one statement concerning it was hardly enough anyway.

What cooperation has the council given the AMA committee on post-war planning?

Answer: None so far, but there will be cooperation later. The council and the committee have had no direct contact but are both interested in some of the same things.

Isn't there some duplication of effort between the council and the National Physicians Committee?

Answer: Yes. But there is no official association between the two bodies.

In its attempt to arrive at a "plan" for medicine, will the council undertake any surveys of public opinion?

Answer: It may. But such surveys are rather expensive to make.

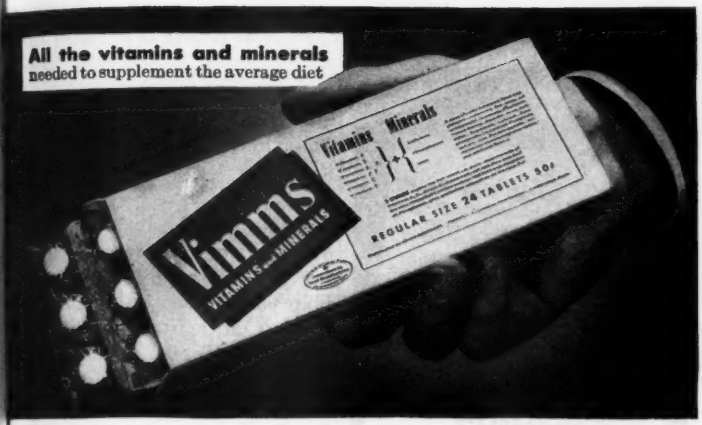
How far has the council gone with its plans for helping demobilized doctors reestablish themselves in private practice after the war?

Answer: A program has been laid out and is now being worked on.

Some of the more openly critical doctors questioned felt that the council's statement of general policies merely echoed similar statements of the AMA House of Delegates. One called the statement a collection of "inconclusive generalities." Another declared that "These policies have been expressed a hundred times before. Their restatement accomplishes nothing. What we need now is action." Several, after reading the policy statement, said, "So what?"

One man observed that "No one impugns the motives or earnestness or ability of the council's personnel. The real issue is lack of results. If the council is handicapped in getting results soon, it should, in fairness to its members and to the profession at large, explain what those handicaps are so that they may be overcome."

—EDWARD S. STEARNS



A Wise Supplement to Wartime Meals

BEFORE food rationing and shortages, 3 out of 4 Americans failed to get enough vitamins and minerals from their food. Today, Vimms offer an especially timely aid to the busy physician. Scientifically designed to bring inadequate diets up to the daily vitamin-mineral levels recommended by the National Research Council, this balanced supplement will help prevent the minor ills that can result from dietary deficiencies.

Why so many doctors recommend Vimms

1. A correct balance* of all the vitamins needed to supplement the average diet . . minimum daily requirements of Vitamins A, B_1, B_2, C, D, and 10 mgs. Niacin.

2. All the minerals commonly lacking . . Vimms supply generous quantities of Calcium, Phosphorus and Iron.

3. Potency guaranteed . . . Vimms potencies are chemically and biologically controlled. Stability is insured.

4. Palatable . . . priced for all . . .Tasty Vimms tablets cost only 50¢ for 24; $1.75 for 96; $5.00 for 288.

*Jour. of the A.M.A., July 18, 1942, pp. 948-9.

For clinical samples, please write to Pharmaceutical Division, Lever Brothers Company, Dept. ME-16, Cambridge, Mass. (Offer good in U. S. A. only.)

3 Vimms a day supply (In terms of a good food source of each vitamin and mineral)

5000 USP Units VITAMIN A	1.0 milligram VITAMIN B_1	2 milligrams VITAMIN B_2 (G)	30 milligrams VITAMIN C	500 USP Units VITAMIN D	10 milligrams VITAMIN P-P (Nicotinic Acid)	375 milligrams CALCIUM	250 milligrams PHOSPHORUS	10 milligrams IRON
as much as 10 pats BUTTER	as much as ¾ lb. cooked LIVER	as much as ⅕ QUART MILK	as much as 5 oz. TOMATO JUICE	as much as 1½ tsp. COD LIVER OIL	as much as ½ lb. STEAK	as much as 1½ oz. Amer. CHEESE	as much as 1½ EGGS	as much as 2 cups SPINACH

Use of the slip method also prevents undone jobs from "nagging" you. You know you're going to get to each one in due time; until then you can forget it.

• • •

Some men are born potterers, others acquire the vice. Organizing tasks with time slips should help you eliminate the tendency in part at least. Is it time to write Mrs. Brown about her examination? Should you go to the ration board about that new tire? Ought that report to be sent to Dr. Smith? Set a time for each chore in your slip schedule—then do it.

• • •

Too many of us waste time in our routine work by failing to seek better ways of doing things. Make a point, therefore, of challenging every method you use. Try this:

1. Write out a description of the procedure on 3″ x 5″ slips, using a separate slip for each step.

2. Study the various steps, asking yourself: "Can I eliminate this step? If not, can I simplify it? How can I get better results?"

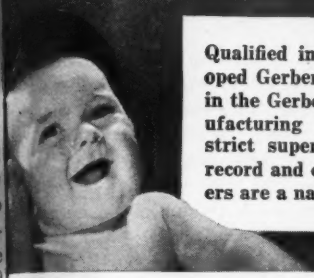
3. Revise your slips as you proceed, then rearrange in the best sequence.

Such job analyses should be made at regular intervals, covering the work of everyone in the office.

• • •

One GP found on analysis that if he were to combine some of

Its clinically successful record speaks for this Baby Cereal!



Qualified infant nutrition specialists developed Gerber's Strained Oatmeal. It is made in the Gerber laboratories, under ideal manufacturing conditions subject to constant strict supervision. Its clinically successful record and enthusiastic acceptance by mothers are a natural consequence.

5 Important Advantages

1. **NUTRITIONAL VALUES.** This cereal is fortified with Vitamins of the B complex as well as iron.
2. **LOW FIBRE CONTENT.** This cereal is processed to be suitable for the delicate intestinal tract of infants as young as three or four weeks. The percentage of fibre present in the dry cereal is exceptionally low. When mixed with milk, it is even lower.
3. **SMOOTH CONSISTENCY.** When infants are first given cereal, consistency is very important. Gerber's Strained Oatmeal has been developed to mix to a smooth, creamy consistency.
4. **APPETIZING TASTE.** Special attention was paid to the taste of Gerber's Strained Oatmeal. How infants appreciate that good flavor as they grow older!
5. **EASY TO SERVE.** This cereal is pre-cooked. Simply add hot or cold milk or formula according to the consistency desired.

IRON AND THIAMINE VALUES OF GERBER'S STRAINED OATMEAL

	Thiamine mg.	Iron mg.
Minimum daily requirement	0.25	7.5
Recommended allowance	0.4	7.5
One ounce Gerber's Strained Oatmeal	0.37	12.0

Calories per ounce: Gerber's Strained Oatmeal 110.

UNRATIONED

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CHOPPED FOODS

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Gentlemen: Kindly send a complimentary sample of Gerber's Strained Oatmeal and a Professional Reference Card to the following address:

Name .....

Address .....

City ..... State .....

the headings on his history card he could save time in entering data. At first his new routine took a little longer because he had to change a habit. But before long he was reaping the reward of valuable time saved.

* * *

Another practitioner's analysis showed that he was wasting quite a few minutes a day because of inefficiently placed equipment that required a lot of unnecessary steps. Another discovered that he was spending time on things that might better be delegated—*e.g.*, going to the reception room door to summon patients instead of letting his nurse do it. Still another discovered that certain statistical counts were being made by his secretary, for which there was no further use; they had been started but not stopped, so the girl continued automatically to make them.

* * *

When you have organized your time, give a thought to the tools you work with. Your desk isn't an attic; so don't pack it full of useless odds and ends.

Another thing: Clear off the top of your desk. A clutter of papers is no longer indicative of a busy man; people now regard it as a sign of inefficiency. Remember, too, that an untidy desk can have an unpleasant psychological effect on those under your care. The patient who views a mass of unfinished business on the desk concludes that you're simply allowing him a few moments between more important tasks.

On the other hand, the one who comes into the consultation room and sees your desk clear of everything but his own case history immediately feels he has your undivided attention.

* * *

A number of companies provide ten-minute rest periods for their employes at 11 A.M. and P.M. daily. Increased efficiency has resulted. The physician might well follow suit, taking his cue from what he would tell a patient in similar circumstances. He'll not only suffer less wear and tear, but he'll also get more done.

—C.B. ORCUTT

Best Sellers for M.E. Readers

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—John Roy Carlson

A SURGEON'S WORLD
—Max Thorek, M.D.

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Free Choice

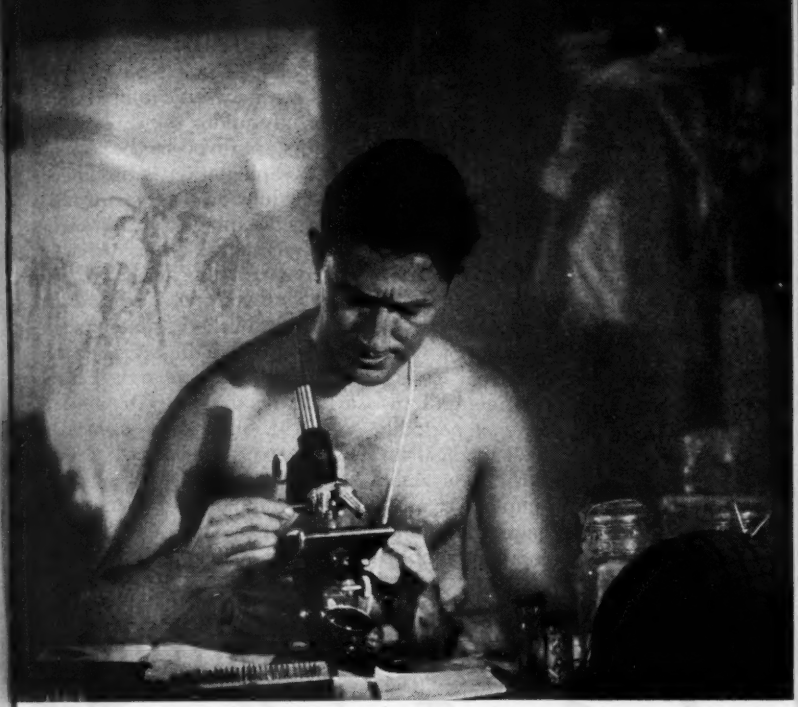
[*Continued from page* 58]

the authority it confers on county medical societies to certify physicians as qualified to handle compensation cases. The societies classify and grade both specialists and GP's according to ability and ethical character. The state medical society coordinates this certification, which is then subject to the approval of the industrial commissioner. Some 95 per cent of the state's physicians have now been certified.

A New York doctor who has been refused certification and who wants to do compensation work may appeal his case to the industrial council. If his appeal is denied, he may thereafter give compensation patients first aid only (unless they are under treatment in a recognized hospital and he is a staff member of the institution).

Also subject to certification and approval by the medical society board are the medical establishments of New York employers. Such facilities may be maintained, but injured workers are not obliged to use them. Moreover, each employer must post a notice informing employes of their right of free choice. It is illegal to ask a worker to sign, in advance of injury, a waiver of that right; but an employer may recommend a doctor if the workman voluntarily asks him to do so.

Should an employe in New York



How Americans Are Kept in Fighting Trim

On some South Pacific island, in Africa, or on our northern battlefronts . . . wherever there is a force of American soldiers . . . you will find a medical officer equipped with a microscope.

Bausch & Lomb Microscopes follow the flag, over land and sea, to help keep your fighting sons in fighting trim. Medical research . . . and the routine checkups and analyses that must be done in the field . . . are a vital part of military preventive medicine. Through the microscope the Medical Corps knows of the enemies . . . disease and infection . . . that lurk behind every battle line.

Microscopes are typical of the many Bausch & Lomb optical instruments that are performing vital war duty on the home front . . . in the industrial research and control that speed the production of the tools of Victory . . . and in the medical and scientific research that will make it a better world to which these boys will return. Here again, optical science is *seeing it through.*

BAUSCH & LOMB

OPTICAL CO. ROCHESTER, N. Y.

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be so badly injured that he is unable to make known his choice, the employer must then select a physician for him. Later, the worker may choose his own doctor to continue the medical treatment.

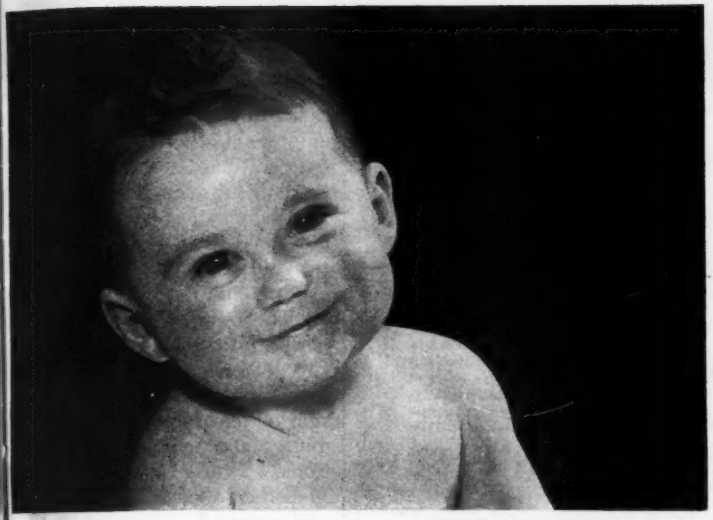
Although this and other necessary transfer privileges are given to the *employe*, the *employer* may transfer a case only under prescribed rules safeguarding both workman and physician.

Insurance companies in New York are prohibited from having a hand in the treatment of injured workers; however periodic examination by their medical investigators is permitted. This right is also given to employers.

"Clinics" and diagnostic laboratories that handle compensation cases must be inspected and approved by the local county medical society. Nurses, physiotherapists, etc. may serve injured workmen only under the direction of doctors approved by the commissioner. Solicitation is prohibited. A schedule of fees is provided; so are disciplinary measures for incompetency and misconduct on the part of physicians.

A New York doctor dissatisfied with established minimum fee may request a higher one. If it is denied, he can appeal to an arbitration board (composed of doctors). Such appeals, incidentally, are often granted.

Compensation service by cultists and unlicensed practitioners is barred by the New York law. Licensed osteopaths, however,



Frankly, we don't believe in frills

DOCTORS don't believe in frills, either.

When it comes to *anything* for a small baby, the simpler the better.

That's especially true of a baby oil. The purer it is, the fewer ingredients it contains, the more likely it is to agree with a baby's delicate skin.

Johnson's Baby Oil is made of highly refined mineral oil with just enough lanolin added to give it extra "slip." It will not turn rancid. In comparisons with other oils, the crystal clearness of Johnson's is particularly impressive.

Johnson's Baby Oil

JOHNSON'S BABY POWDER

is made of finest talc—which alone can *insure* the smoothness and gentleness of the finished product. It is lightly borated.

More doctors, nurses and hospitals recommend Johnson's Baby Powder than all other brands put together.

Send for 12 free trial bottles of Johnson's Baby Oil

JOHNSON & JOHNSON,
Baby Products Division, Dept. 925,
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Please send me, free of charge, one dozen sample bottles of Johnson's Baby Oil.

Name_____

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Offer limited to medical profession

Johnson & Johnson
NEW BRUNSWICK, N. J. CHICAGO, ILL.

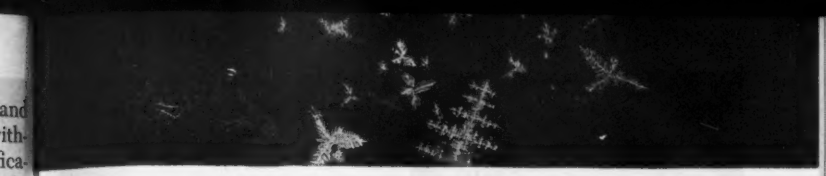
are regarded as physicians and may treat injured workmen within the range of their qualifications. In several other states, the employe has the right to select a cultist if he so desires.

All in all, the New York law guarantees a just handling of most industrial cases. To amend it to provide free choice required: (1) experimentation with the free-choice principle over a two-year period (1931-33) in New York City; (2) the appointment by the Governor (1933) of a commission of ten doctors to study the matter and make recommendations; (3) the close cooperation of medical societies, labor unions, and reputable insurance companies in constructing the amendments deemed necessary.

The state legislature, finally convinced that reform was imperative, approved the amendments in July 1935.

Even though the New York statute is a modern and enlightened one, problems still arise and minor abuses still occur. With all the safeguards a number of workers still don't realize that they are free to choose their own doctors. Others know they have free choice, but follow their employer's suggestion because they don't want to antagonize him. Sometimes, too, an insurance adjuster or a union official will attempt to coerce a worker into giving up the physician of his choice.

Thus, even under a fair law patients may still be taken from their family physicians. To combat this evil, each New York doc-



THE UNIQUE VASOCONSTRICTOR-SULFONAMIDE

UNLIKE the usual intranasal sulfonamide preparations, Paredrine-Sulfathiazole Suspension is not a solution of the sodium salt of sulfathiazole, but an aqueous SUSPENSION of 'Micraform' sulfathiazole crystals.

These minute crystals—*approximately 1/1000 the mass of ordinary commercial crystals*—form a fine, smooth coating of sulfathiazole, free of clots and clumps, which is evenly "frosted" over the affected nasal mucosa.

This coating produces a reservoir of sulfathiazole which exerts a prolonged and sustained bacteriostatic effect. It does not interfere with drainage, and is gradually, yet completely, removed by ciliary action and by absorption.

Paredrine-Sulfathiazole Suspension combines the non-stimulating vasoconstriction of 'Paredrine' with the potent bacteriostatic action of 'Micraform' sulfathiazole. Its slightly acid pH range (5.5 to 6.5) is *identical with that of normal nasal secretions*—a vital consideration in any preparation for intranasal use.

Paredrine-Sulfathiazole Suspension has proved strikingly effective, both with adults and children, in the treatment of nasal and sinus infections—particularly those secondary to the common cold. Furthermore, it may often prevent dangerous sequelae, such as otitis media, mastoiditis, bronchitis, pneumonia, etc.

1 'MICRAFORM' SULFATHIAZOLE
2 NON-STIMULATING VASOCONSTRICTION
3 THERAPEUTICALLY IDEAL pH

When a vasoconstrictor alone is indicated—

***It's* PAREDRINE HYDROBROMIDE AQUEOUS**

tor who learns of such a case is urged to report it, with all available proof, to his county medical society. Employers and insurance carriers found guilty of case-lifting are subject to penalties under the law.

As a further curb on abuses, and to coordinate the work of the sixty-odd county societies in New York, the state medical association provides the services of a physician to act as medical director of workmen's compensation. This arrangement has been particularly valuable in obtaining the cooperation of employers and carriers and in furthering the processes of arbitration, especially in the matter of fee disputes.

About the genuine progress achieved in New York, there can be no doubt. Amendment of the statute has brought thousands of highly qualified physicians into the compensation field—including many who previously were reluctant to accept industrial cases. Thus, workmen now have an opportunity to select from the best doctors in the state.

Many legal difficulties have been smoothed out, too. Wiser arbitration provisions have reduced the number of lawsuits. Insurance companies have been compelled to assume a more responsible attitude. And, finally, the law has proved that free choice, under proper control, is the logical solution to most medico-economic problems in the workmen's compensation field.

—RUSSELL DANE

Study Program

[*Continued from page* 54]

outspoken in his praise of the program. In fact, from all over the country the central committee has received enthusiastic endorsements of the plan from men dorsements from men in mufti as well as from those in uniform.

To this central committee is due a large share of the credit for the program's success to date. Chairman of the committee is Dr. Edward L. Bortz of Philadelphia; his associates are Dr. William B. Breed of Boston and Dr. Alfred Blalock of Baltimore.

Many physicians have expressed the opinion that with the faculty set up as a going institution, this great pooling of medical teaching talent deserves to be more than a wartime measure. Here potentially is a permanent "university extension movement" for American medicine.

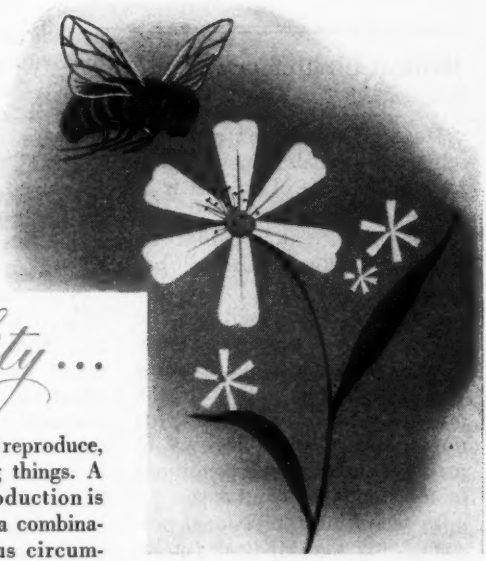
—NELSON ADAMS

Patient-Doctor Ratio

[*Continued from page* 65]

Although Georgia has only about two-thirds as many doctors as Maryland (in relation to population), the patient load of the average Georgia practitioner is lower than that of his Maryland colleague. Reason: Georgians go to their doctors less often than do Marylanders. Most Georgia physicians substantiated this fact by declaring that they could carry heavier patient loads.

—J. W. MC KIRNAHAN



Fertility...

● Fertility, the ability to reproduce, is common to all living things. A complex process, reproduction is generally facilitated by a combination of most fortuitous circumstances. At times, however, as in human "sterility", anomalous factors occur to thwart Nature's intended purpose.

MacLeod and Hotchkiss* have recently shown that some particularly confusing instances of clinical infertility can be attributed to sub-normal sperm migration, possibly resulting from incompatible genital secretions. In cases of this type, fertility may be restored through the use of a physiologic glucose douche. Glucose, metabolized by the sperm, acts therapeutically by providing nutrient for sperm motility.

Nutri-Sal, a physiologic glucose douche powder, is recommended in the treatment of infertility, where none of the well-defined factors, such as anovulation, unpatent tubes, endrocrine dyscrasias, etc., are present. It may also be employed as a therapeutic adjuvant during the routine investigation of sterility, since it is safe and convenient to use, and may obviate the necessity for some of the more complex analytical procedures.

*AMER. J. OBST. & GYN., SEPTEMBER, '43

Nutri-Sal

FOR USE IN SELECTED CASES OF INFERTILITY

ORTHO PRODUCTS, INC., LINDEN, N. J.

Medical Intelligence

[*Continued from page* 55]

Headquarters of the Medical Intelligence Branch is in Washington, but its field of interest is as global as the war.

Since its inception in 1941 the Medical Intelligence Branch has prepared more than 150 reports on areas in many parts of the world. Some of these reports require frequent revision, for they must be accurate and up to the minute when needed. MIB is now making other surveys of medical and sanitary conditions in areas on every continent.

In recruiting professional personnel for the Medical Intelligence Branch, successful efforts were made to obtain specialists whose qualifications and experience fitted them for the work of gathering, compiling, and evaluating technical information. Ability to read foreign languages is a must.

In making surveys, information is gathered from all available sources and checked and cross-checked to insure its accuracy. The million-odd books, technical periodicals, and manuscripts in the century-old Army Medical Library (the largest and most complete in existence) contain invaluable information about medical conditions in many parts of the world. So do the collections of the Library of Congress and the library of the Department of Agriculture.

Valuable information is obtainable from many other sources too. Some general information about world conditions is supplied by organizations like the National Geographic Society; specialized technical information, by others like the Pan-American Sanitary Bureau. Some government departments have done extensive work in certain fields of sanitation—the Department of Agriculture, for example, in mosquito control.

Many American physicians who have practiced in other lands, and are now in the United States, supply first-hand information about various war areas. Meteorologists, climatologists, and other non-medical scientists connected with government departments likewise serve as good sources.

—ARTHUR GRAHAME

"My Most Interesting Experience"

This new department—see page 99—gives every physician-reader an opportunity of telling his confreres about that one case which gave him the biggest kick of all. *Medical Economics* will pay $5-$10 apiece for acceptable descriptions of such incidents—amusing, exciting, embarrassing, or amazing. Address your manuscript to Interesting Experience Editor, Medical Economics, Rutherford, N.J.

What They're Reading

CHINA'S HEALTH PROBLEMS

By Szeming Sze. 60 pages. Chinese Medical Association, Washington, D.C. $1.

China's struggle for survival against a ruthless invader is no more titanic than her battle with the incubus of disease. Both are long, uphill fights against seemingly hopeless odds; but just as the meagerly-equipped Chinese army has often stood steadfast against the powerful, mechanized Japs, so are the republic's pathetically inadequate medical forces presenting a thin-drawn but resolute front against illness and pestilence.

Dr. Sze (general secretary of the Chinese Medical Association and editor of the Chinese Medical Journal) seeks in his book to answer some of the questions Americans have asked about China and her doctors. It is not easily done. China's health problems, the doctor indicates, are vast and complex. His statistics are chilling:

With a morbidity rate of 4 per cent in a population of 400,000,000, some 16,000,000 Chinese are ill at any given time. The mortality rate is 25 per 1,000, so 10,000,000 persons die each year. Diseases that are yielding to control in much of the rest of the world are still rampant in China. Dr. Sze lists, for example, 150,000,000 current cases of trachoma, 40,000,000 of syphilis or gonorrhea, 32,000,000 of tuberculosis, 1,000,000 of leprosy.

To meet this scourge, China has 12,000 physicians, less than 6,000 of whom are effective. By minimum standards she needs 266,000. There are 38,000 hospital beds; she needs 2,000,000.

In all China, there are just twenty-eight medical colleges: ten national, nine provincial, and nine private. Small schools and low standards accentuate the problem. A tentative program to develop better teachers by government subsidy has had to be suspended.

Only 25 per cent of the doctors—3,000—are members of the Chinese Medical Association. The rest, whose qualifications are questionable, are members of the Medical Practitioners' Federation, an organization of practitioners' unions, which "doctors" may legally join, regardless of qualifi-

cations. Cooperation between the CMA and the unions is not expected until time thins out the ranks of the incapable.

Between floods in the valleys and droughts in the northwestern plains, China's famines are frequent. And although 84 per cent of the population lives in rural areas, virtually all modern medical facilities are concentrated in the cities. Most of the rural population is unable to pay for medical attention; so state medicine is said to appear necessary there. In the cities, however, Dr. Sze indicates, the popular demand for private practitioners makes government subsidy unlikely.

Despite appalling conditions now prevailing throughout the country, the Chinese Government has prepared the groundwork of a national health program. Admittedly inadequate, it provides for 100 health centers for each of the twenty-four provinces, with thirty emergency hospital beds in each center. In addition, every county will have a health center, supplemented by smaller village stations.

Up to 1942, 783 district health centers, together with sixteen provincial centers and fifteen provincial hospitals, had been established. It is proposed that 160 existing non-governmental hospitals be integrated in the system. Most of them are mission institutions, but they are gradually com-

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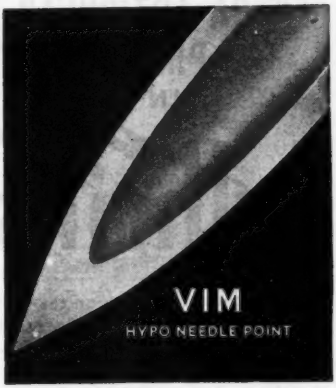

Now you may get all the VIM NEEDLES you need . . . in all these gauges and lengths, right away. Your surgical dealer has an adequate stock of VIMS . . . the needle made from genuine Firth Stainless *Cutlery* Steel. Fill your requirements now . . . replenish your reserve stock . . . while you can get such prompt delivery. To get genuine VIM NEEDLES always specify "VIM."

GAUGE	LENGTH	PRICE DOZ.	GAUGE	LENGTH	PRICE DOZ.
27	⅜"	$2.50	22	1 "*	$3.00
27	½"	2.50	22	1¼"*	3.00
26	¼"	2.50	22	1½"*	3.00
26**	⅜"	2.50	22	2 "	3.50
26	½"	2.50	21	1¼"	3.00
26	⅝"	2.50	21	1½"	3.00
25	⅓"	2.50	20	1 "*	3.00
25	⅝"	2.50	20	1¼"	3.00
25	¾"*	2.50	20	1½"*	3.00
24	½"*	2.50	20	2 "	3.50
24	⅝"	2.50	19	1¾"	3.50
24	¾"*	2.50	19	2 "	3.50
23	⅝"	2.50	19	2½"	4.00
23	¾"*	2.50	18	1½"*	3.50
23	1 "	2.50	18	2 "	3.50

**Schick

*Also with intravenous point

MacGREGOR INSTRUMENT COMPANY, *Needham, Mass.*

ing under Chinese control as local support is provided.

The government medical program embraces the work of many organizations: the National Health Administration; the National Institute of Health (concerned with training and research); an epidemic prevention bureau; a central narcotics bureau; and factories for the production of drugs and surgical equipment. The National Relief Commission and the Chinese Red Cross function in emergencies. In addition, the Health League of China, organized in 1940, fosters sanitary education in regions not reached by the government centers.

The United States has been helping the National Health Administration and the army since 1940 by supplying lend-lease medical material and technical personnel. Red Cross help came from several nations until 1939; the American Red Cross is now the only organization continuing it.

However, other groups are aiding the national medical program, among them such organizations as United China Relief, the American Bureau for Medical Aid to China, the Associated Boards for Christian Colleges in China, and various missionary bodies and relief organizations.

Dr. Sze's factual story does not blink at the immensity of the medical problem his nation faces. But it is evident that he believes it will be solved in time.

—CRERAR HARRIS

The Newsvane

Hospitals that Hoard

Some hospitals have available to them a disproportionate number of physicians who are ineligible for military service and are therefore making little effort to reduce their staffs, Dr. Harold S. Diehl, a member of the Procurement and Assignment Service directing board, charged recently. "Any institution which retains on its staff more physicians than are absolutely necessary is guilty of hoarding and is prejudicing the war effort and the national welfare," Dr. Diehl declared.

Dr. Diehl also made the accusation that some physically fit doctors of military age are avoiding service by offering to serve as residents with the understanding that hospitals will request their deferment by Selective Service.

Britons Decry State Plan

A number of doctors serving in the British armed forces are demanding that action be postponed on government proposals for state medical service until after the war, when the absent men will be able to have their say about medical socialization. One physician, serving on the Burmese frontier, wrote to the British Medical Journal:

"After some years in the army one hates the idea of the regimentation any state service entails. We shall refuse to conform with or abide by any decisions made while we are serving overseas."

R.I. Medical Benefits

Help may be extended to Rhode Island families, normally self-supporting, who suffer unusually severe or expensive illness, says Gov. J. Howard McGrath, in announcing an extension of the state's disability insurance program. In operation since last April 1, the program has aroused considerable controversy.

Governor McGrath, who describes himself as an opponent of socialized medicine, contends that the broadened state program will avert any need for subsidizing medical care for persons, ordinarily solvent, who are unable to pay for such care in emergencies. He reports that physicians are cooperating in the program.

At present, about 350,000 contributing workers, nearly half the state's population, are eligible for weekly benefits (ranging from $6.75 to $18) when earnings are cut off by illness. Each pays 1 per cent of his earnings into a state medical fund.

Critics of the program assert that it opens the way to social abuses. The Providence Medical Association, for instance, has charged that

the sick benefits of some workers would exceed their wages. This is denied by the legislation's sponsors and by Mortimer W. Newton, head of the State Unemployment Compensation Board.

Package Benefits

A "package plan" of insurance—covering life, illness, accident, surgical fees, and hospitalization—is now offered to all Minnesota state employes under the age of 65 who have put in six months of continuous service. The Minnesota Hospital Service Association is cooperating in the plan, recently set up by the state legislature, which authorized payroll deductions to finance its operation.

Army Declines Neurotics

Don't advise an emotionally unstable youth to go into the Army because it will "make a man of him," urges Col. Roy D. Halloran, chief of the Army's neuropsychiatric division. He reports that the service has never had enough psychiatrists to screen out all neurotics and that, consequently, a large number of men unfitted for military life have gotten into uniform. Control has been tightened, however, with the placing of psychiatrists in each induction center, he says, and present policy is to defer the induction of youths between 18 and 21 for re-examination within six months if they are adjudged physically or mentally immature.

Insurance Checks

"Do not accept checks from insurance companies for fees of patients carrying medical or surgical indemnification policies," advises the California Medical Association.

which suggests that doctors return such checks to the issuing companies with a simple statement that the matter of payment is being handled directly with the patient. "Doctors are under no contractual obligation to the insurance carrier," says the association, "but are dealing directly and only with the patient under the usual physician-patient relationship. If the insurance company wishes to send its indemnification check to the patient, that is a matter between it and the policyholder."

Hon. Learned Professors

Japan plans to reopen the medical college in Batavia, Java, which has been closed since 1942, when the invaders interned its faculty. Eighteen "learned" Japanese professors, the Netherlands Information Bureau reports, are coming to Java to form the new staff.

Netherlanders in Australia point out that it is impossible for the "learned" Japanese to have become sufficiently proficient in the Malay tongue in a little more than a year to be able to teach medicine in that language. Therefore, they deduce, either the Japanese have been preparing for the project since long before the war, or the reopened college is foredoomed to failure.

Woman Doctors' Incomes

American woman doctors enjoy a higher average income than do their sisters in any other professional group in the United States, according to a survey made by the National Federation of Business and Professional Women's Clubs. The average annual income of 227 feminine physicians, surgeons, and osteopaths reporting was $2,835, compared with $1,547 for the entire professional group. Thirty-seven of the woman doctors—16 per cent—earned between $5,000 and $10,000; eight made $10,000 or more.

Student Protest Halted

A service regulation was invoked recently to forestall activity against the Wagner health bill by naval students at the Medical College of the State of South Carolina.

The students had unanimously endorsed the action of the state medical society in damning the bill as "totalitarian" and had planned to appeal to more than sixty medical colleges in the nation to join the fight. Shortly thereafter, this notice was posted on the college bulletin board: Navy V-12 students by regulations are not allowed to participate in any form of political activity or join in any movement concerning government policy."

Bias in Ads Barred

Advertisements specifying or implying racial or religious qualifications for medical posts have been barred by the Journal of the New York County Medical Society. In a resolution adopted last June, the society chided the Journal AMA for admitting discriminatory ads to its

"...not Sick, Doctor, but oh so TIRED and ACHY!"

Excessive Fatigue, Tired, Aching Feet, Rheumatoid Foot And Leg Pains, Vague Pains In The Lumbar Region—Often Due To

WEAK FEET and FLAT FEET

BETWEEN the ever-mounting number of cases of Occupational Foot Troubles our war effort is producing, and the steady absorption of Physicians in the armed forces, Dr. Scholl's Foot Comfort Service can be of very real assistance to the profession at home in helping to quickly dispose of cases involving the feet.

By referring patients whose symptoms point to breaking down of the foot arch structure, to any Shoe, Department Store, Surgical Supply Store or Dr. Scholl's Foot Comfort Shop, where Dr. Scholl's Foot Comfort Service is featured, their needs will be adequately met at small cost.

If Dr. Scholl's Arch Supports are indicated, the individual requirements of the person will be carefully met. They are scientifically designed in a full range of sizes and types for all purposes. By relieving muscular and ligamentous strain, relief soon follows. Dr. Scholl's Arch Supports are light, resilient, adjustable as the condition of the feet improves.

DR. SCHOLL'S FOOT-EAZER *and exercise relieve tired, aching feet; rheumatoid foot and leg pains. Help restore weak and fallen arches to normal. Worn in any shoe. $3.50 pair.*

Dr. Scholl's Pedograph graphically reveals the nature and extent of any foot arch weakness. Prints of stockinged feet made without charge.

•

Dr. Scholl's Foot Comfort Shops Are Located in the Following Cities:

Akron, Albany, Boston, Bridgeport, Buffalo, Canton, Chicago, Cleveland, Columbus, Dayton, Detroit, Duluth, Elgin Fargo, Fort Wayne, Grand Rapids, Harrisburg, Hartford, Indianapolis, Jamaica, Kansas City, Long Beach, Cal., Los Angeles, Milwaukee, Minneapolis, Muskegon, New Haven, Newark, New York, Omaha, Peoria, Philadelphia, Phoenix, Rochester, Sacramento, St. Louis, St. Paul, San Bernadino, San Diego, Schenectady, Seattle, Spokane, Springfield, Mass., Toledo, Trenton, White Plains, Wilkes-Barre, Worcester

See Classified Telephone Directory

*TRADE MARK REG. U. S. PAT. OFF.

Dr. Scholl's Foot Comfort ARCH SUPPORTS

"physicians wanted" column. Members then discovered that the issue of the county journal containing the resolution also carried the advertisement of a "gentile neuropsychiatrist" looking for a position.

Sight Factor Revealed

The ordeals of the Maltese people have brought about the discovery of a food factor—as yet unidentified, but believed to be a vitamin—essential to normal night vision, it was disclosed at the annual meeting of the Association of Military Surgeons of the United States by Air Marshal Sir Harold E. Whittingham, director general of the Royal Air Force Medical Services and honorary physician to the King. The vision-sharpening substance, he reported, is contained in fresh fruits, particularly those of the citrus group.

Sir Harold attributed the discovery to Squadron Leader Thomas Macrae, nutritionist, and Wing Commander Keith Lyle, ophthalmologist The two men, having observed that the Maltese people appeared deficient in night vision, made a number of tests in which subjects were taken to the mainland and given orange juice as part of their diet. In about a week their vision returned to normal.

Policeman Delivers 17th

Patrolman Samuel Van Gilder of Philadelphia delivered his seventeenth baby recently with the deftness that comes of long practice. His station house had received a hurry-up call, and the desk sergeant had dispatched Van Gilder to the scene of action. The trouble-shooter was a medical student before joining the force twenty-seven years ago and has since gained a working

SIMILAC is cow's milk completely modified by laboratory methods. The fat is well suited to the infant's requirements. The protein is easily digestible (zero curd tension). The carbohydrate is all lactose. Even the minerals are adjusted to closely approximate those of human milk.

One level tablespoon of the Similac powder added to each *two* ounces of water makes two fluid ounces of Similac. The caloric value of the mixture is approximately 20 per fluid ounce.

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

SIMILAC } SIMILAR TO BREAST MILK

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familiarity with obstetrics. While the father of the arriving boy paced the floor in traditional fashion, Van Gilder attended the mother, wrapped the infant in cotton and blankets, then hurried it to a hospital.

British Babies Thrive

The health of Britain's babies is better than ever despite "a pretty narrow" allowance of food under rationing, Dr. Dorothy Mary Taylor, senior medical officer of the British Ministry of Health, declared on her recent arrival for a study of maternity and child care agencies in this country.

She explained that a new mother in Britain is allowed extra rations of milk—one pint a day for herself and another for the baby. She may use the entire quart herself if the baby is breast-fed. In addition, her meat ration is increased, and a special allowance of concentrated orange juice is provided for both mother and child.

Expectant mothers and babies under 5 get priorities for eggs and vitamins A and D in cod liver oil and capsules.

Stutterers Fail in Army

Many stutterers are unfit for military service because Army life accentuates their affliction, declares Dr. James Sonnett Greene, medical director of the National Hospital for Speech Disorders in New York. The hospital conducts day and evening clinics for service men.

Stutterers should be rejected at induction centers, Dr. Greene believes. "When one breaks down in the Army," he explains, "not only is his own emotional health endangered, but he ties up the services of physicians and nurses sorely needed in other quarters."

Federal Cancer Aid Asked

A broader program of cancer control after the war, with increased federal support, has been urged by Representative Edith Nourse Rogers of Massachusetts. Addressing a recent meeting of the Women's Field Army of the American Society for the Control of Cancer, she called for the immediate planning of enlarged hospital, diagnostic, and clinical facilities.

The cancer problem is increasing, Mrs. Rogers warned, there being about 500,000 current cases and 160,000 deaths a year.

Doctorless Miners Strike

Left without a doctor by the induction of the community's one practitioner, the 350 miners who live in Birch Grove, Nova Scotia, went on strike recently until they received assurance that medical attention would be provided for them and their families.

Industry's Need

As evidence of the unprecedented burden of work now being borne by industrial physicians, Dr. Clarence D. Selby, speaking at the re-

cent Wartime Public Health Conference of the American Public Health Association, in New York City, cited an industrial plant whose employes have increased more than 100 per cent yet whose doctors have increased less than 11 per cent—from 115 to 127. The condition is doubly appalling, Dr. Selby said, in view of the fact that a number of the concern's new employes are over-age, physically handicapped, or both. Dr. Selby is chairman of the Committee on Industrial Health and Medicine of the Procurement and Assignment Service, and medical consultant to the General Motors Corporation.

Air Ambulance Service

A civilian aerial ambulance service intended primarily for emergency transportation, is being provided by Relief Wings, Inc., a nonprofit organization in New York City. Those able to pay full cost are charged 14 cents a mile for the service, but it is available to charity patients at a rate of 5 cents a mile.

Eight-Surgeon Operation

Three teams—eight surgeons in all—worked simultaneously for six hours at a field hospital near the front in Italy recently to save the life of a critically injured Army pilot. A young lieutenant, due to return to the United States after making a number of missions over enemy territory, was wounded by strafing as he traveled along a highway toward the rear. When he was brought into the Ninth Evacuation Hospital, it was discovered that he had been severely injured in the head, abdomen, and leg. Lieut. Col. Sigurd Sandzen, of New Rochelle, N.Y., a member of the hospital staff, immediately called for the services of the three operating teams.

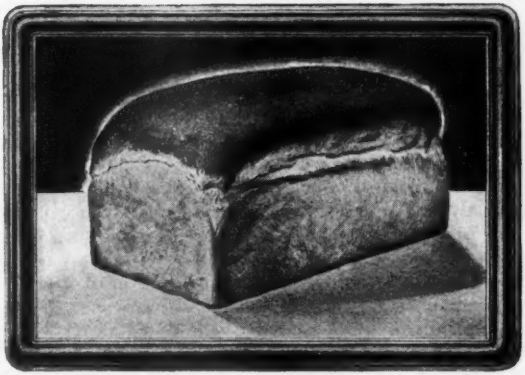
While they operated, the eight surgeons were grouped so closely around the table that there was constant hazard of a mishap. In addition, whole blood, plasma, and oxygen had to be administered to the flier as the surgeons worked.

Short Insurance Form

A short form, designed to save the time of busy physicians who supply information to insurance companies, lodges, and benevolent orders, is being distributed at cost to members of the Academy of Medicine of Cleveland. The academy suggests that the doctors ask no fee for filling out this standard form, but make a suitable charge for supplying information on the companies' longer forms.

New Hospital Plan

Louis H. Pink, president of the Associated Hospital Service of New York, has announced a new hospital plan to supplement the "3 cents a day" program which, at the time of Mr. Pink's announcement, had enrolled 1,300,000 subscribers. The new plan, available at a cost of about 2 cents a day, will provide ward accommodations instead of



FRONT AND CENTER IN THE FOOD PICTURE

FOOD has become a major concern. Is America to fare well or badly? Is good nutrition out for the duration? Will patients be able to obtain readily the foods you prescribe?

Bread as it stands today gives an answer. For it is a finer food today than it has ever been before. It is plentiful. It is inexpensive.

Even those who used to find fault with white bread now praise it.

The government sets bread up in one of the basic seven food groups which should be eaten every day.

Why? Because modern enriched white bread is a storehouse of food-energy and stepped-up nutritional values.

Because it contains abundant carbohydrates to be turned into energy so necessary these busy days.

Because it provides important amounts of thiamin, riboflavin, niacin, important elements of the vitamin B complex.

Because it contains calcium and iron.

Because it provides protein—with a good supply of threonine, an amino-acid most recently proved essential to life and growth. In fact, the threonine content of bread compares favorably with that of those excellent protein foods, meat and milk.

This is why bread is so important in the present-day food picture. It is why bread may be prescribed and recommended with full assurance that more than ever it is basic in every normal diet.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Bread *is basic*

***with* meals... and *in* meals**

FLEISCHMANN 1868-1943—*75 YEARS OF GOOD YEAST FOR GOOD BREAD*

the semi-private rooms available under the older plan, and will cover use of operating room and X-ray facilities, medication, drugs, and dressings.

The benefit period will be twenty-one days. Maternity benefits, limited to $4 a day for ten days will be available only under the family contract, but full benefits will be made available in the event of complications.

Rates were announced as 56 cents a month on an individual contract and $1.32 for a family contract.

Mr. Pink said that 105 hospitals had accepted the ward plan and that enough others would probably join to permit Associated to put the program into operation.

Arkansas Out

Arkansas has discontinued participation in the Children's Bureau program of maternity aid to wives of service men, it was announced by Dr. W. B. Grayson, state health officer. The state Board of Health voted to withdraw, said Dr. Grayson, because of the "paper work and red tape involved in the federal project." He asserted that dissatisfaction with the plan was widespread among Arkansas physicians and that the council of the Arkansas Medical Association had voted to urge discontinuance of participation by the state.

Turnabout

Grocery store chains in many states now stock as many drug lines as the drug chains and small drug retailers with whom they compete, according to a survey made by Edward L. Bernays, public relations counsel of a chain-store association.

Few Wounded Die

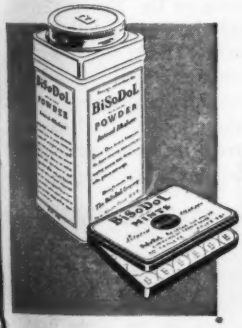
Although 10,000 casualties were evacuated from Pacific combat areas in twenty-one months by his hospital ship, reports Capt. Melville J. Alston, USN, chief surgeon of the vessel, only sixteen patients died. Captain Alston said that the low mortality was attributable to the early use of sulfonamides and blood plasma.

Leahy Lauds M.D.'s

Admiral William H. Leahy, President Roosevelt's chief of staff, in paying tribute to the hardihood and courage of medical men in the armed forces, has confessed that he was astounded by his first sight of eminent specialists, not long out of civilian practice, driving nails

PATIENT TYPE No. 6

Copies of the above picture without advertising, suitable for framing, may be had upon request (size 8½ x 10). Write to Dept. F.



THE BISHOP is a tireless committee worker—his increased activity brought about by the war often leads to nervous indigestion and stomach distress. He will be grateful for BiSoDoL—the effective antacid alkalizer. Three tablets or one teaspoonful of powder helps bring prompt relief from distress due to excess stomach acidity.

BiSoDoL

Reg. U. S. Pat. Off.

POWDER · MINTS

The BiSoDoL Company · New Haven, Conn.

and installing plumbing as they helped to build a South Pacific base hospital.

The admiral also praised the men of the South Pacific Air Transport Command. "Up to now," he said, "they have flown 15,000 wounded and sick back from the front to evacuation hospitals with fewer than ten deaths occurring in actual fighting. Planes have frequently been attacked but we have not lost one to the enemy.

"We of the Navy also remember," the admiral continued, "a 60-year-old naval medical officer who refused to abandon a sinking cruiser off Savo Island. He went down with his ship while helping men over the side and easing the suffering of the wounded.

"We remember the flight surgeon who was mortally wounded while loading casualties aboard a hospital plane, but nevertheless refused medical aid and insisted on being carried from one wounded man to another so that he could administer morphine to them."

Sees Ten Year Service

Most physicians now in armed forces face the possibility of being retained for periods up to ten years, in the opinion of Dr. Morris Fishbein, who told the New York Academy of Dentistry that the absence of these doctors "will raise special problems for many hospitals and many communities which have tried to protect for the absentee the place that he held."

Aid for Critical Areas?

Hinting that the U.S. Public Health Service may have to come to the rescue of many communities where there is an acute shortage

NO FLAME

NO WATER BATH

NO HEATING

WHEN YOU TEST FOR *URINE-SUGAR* WITH

CLINITEST

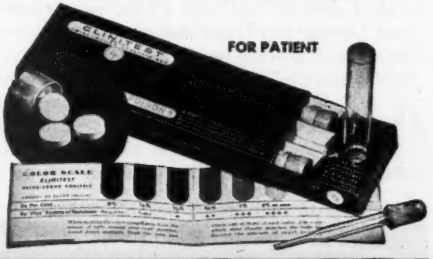
A TABLET COPPER REDUCTION METHOD

AS SIMPLE AS THIS: Just add 1 Clinitest Tablet to proper amount of diluted urine in test tube. Allow for reaction. Compare with color scale.

That is all—

No powder to spill—No measuring—Test in a matter of seconds! . . Available through your prescription pharmacy or medical supply house.

Write for full descriptive literature. Dept. ME-12



EFFERVESCENT PRODUCTS, INC.
ELKHART, INDIANA

of physicians, Dr. Thomas Parran has disclosed that 600 doctors and dentists will be needed in critical areas within a year. Dr. Parran, Surgeon General of the Public Health Service, said that "efforts to maintain at least a minimum ratio of effective practicing physicians in the expanded war industrial centers have not fully succeeded." He revealed that 213 communities were facing the winter with dangerously depleted medical facilities. These areas need, Dr. Parran estimated, some 300 doctors and fifty dentists.

Proposals have been made, the Surgeon General said, that Public Health physicians and dentists be assigned to communities in need of medical personnel.

"Patients would pay for the service when able to do so," he said, "but fees would be turned over to an appropriate local organization—such as the health department—which would operate clinic facilities.

"Another method proposed is for the Public Health Service to assist in the relocation of civilian physicians on a contract basis. Doctors who would agree to practice in a critical area for one year would be paid for the first three months and the costs of moving would be borne by the service."

Drug Store Sales Soar

Drug store sales are expected to total $2,850,000,000 this year, an increase of 25 per cent over last year's sales, and 82 per cent above those of 1939, according to Nelson A. Miller, chief of the distribution-management unit, U.S. Bureau of Foreign and Domestic Commerce.

Armed Forces Healthy

The health of the armed forces is generally excellent, says the Office of War Information. In the continental United States the only disease that reached epidemic proportions this year, says the OWI, was cerebrospinal meningitis, but the resulting death rate was low. An even better level of health has been maintained overseas, marked especially by control of diseases for which vaccines are available. Malaria and dysentery, however, have presented serious problems in land combat conditions, and the Navy has had some difficulty with infectious jaundice and filariasis.

"Ailing" Workers

The War Manpower Commission has disclosed that many workers who are seeking releases from jobs are presenting medical certificates that the work they are doing is deleterious to their health. Investigation has disclosed, says the WMC, that many of these workers have been employed a long time in their "deleterious" jobs and that their records show little absenteeism due to ill health. The commission therefore has requested physicians not to issue such statements unless posi-

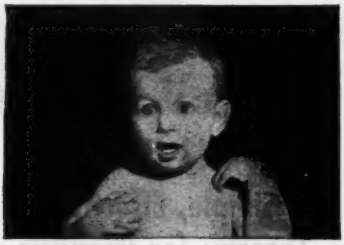
An Essential Factor in

CZEMA THERAPY

Achieved by **SUPERTAH** (NASON'S)

The success of a coal tar ointment in CZEMA THERAPY depends upon *ntinuity* of use for ten to twenty days or ore. But *black* coal tar has a repulsive ppearance and odor, stains clothing and nens, and may burn or irritate the skin, aking continuity of use hard to enforce.

-month old baby with moist zema on face, chest, arms and nds, and secondary infection.



After two weeks treatment with SUPERTAH — All irritation has practically disappeared.

SUPERTAH (Nason's) overcomes such difficulties. It is WHITE, almost odor-free, and non-staining, non-burning, non-irritant, non-pustulant. It need not be removed when renewing applications.

At the same time, say clinical reports,* SUPERTAH "has proven as valuable as the black coal tar preparation." And a survey of U. S. physicians reveals that 88.1% of those prescribing SUPERTAH found it to produce *"Good Results!"***

*Swartz & Reilly, *"Diagnosis and Treatment of Skin Diseases"*, p. 66
**Survey by independent research organization; details on request.

TRADE MARK SPHINX

SUPERTAH
(NASON'S)

At leading prescription druggists
2 oz. jars (5% & 10% strengths)

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ndall Square Station, BOSTON 42, MASS.

INDUSTRIAL PHYSICIANS: SUPERTAH is achieving gratifying results in Industrial Eczemas. Because pleasant and easy to use, it is especially valuable where close supervision is impractical. Write for physician's sample.

tive evidence exists to support them. Where a doctor finds it desirable to issue a certificate he is requested to give specific reasons for it and to state what type of work is suitable for the person seeking a release.

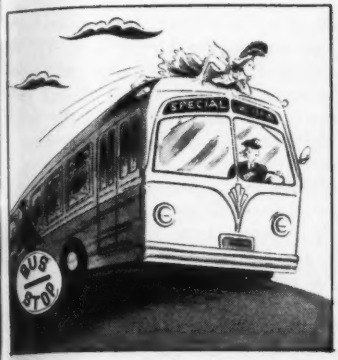
Trial by Jury

The medical profession in New York State has been bluntly accused of refusing to submit to judicial discipline and of "indifference to the rights of the accused" in trials before its own grievance committees. The charges were made in the letter columns of the New York Times by Edward G. Griffin, who participated in the writing of a number of medical, dental, and veterinarian practice acts now in force in New York State. Later, Dr. George R. Harris, of Pittsburgh, Pa., used the Times columns to question the validity of Mr. Griffin's charges.

Asserting that the "medical kickback" scandal is "the direct result of attempts at bureaucratic regulation of the medical profession," Mr. Griffin declared that "there will always be scandal and inefficient policing while physicians, surgeons, dentists, and veterinarians are allowed to regulate themselves through their own membership."

Discipline of the professions, Mr. Griffin asserted, should be placed in the hands of the courts, as it has been in the case of lawyers. Actually, he said, each profession tries members before a grievance committee of its own, subject to review, on conviction only, by the Appelate Division of the State Supreme Court.

"The accused, under such a system, is at a great disadvantage," Mr. Griffin contended. "A board of doctors has few qualifications to



1. I'm Minerva, goddess of Wisdom. That's me on top of the bus, keeping an eye on another gal named Minerva who's filling the job of a man gone off to the wars. She's doing fine, but—

2. She's one of those people whose nerves are upset by caffein and she can't sleep. I catch her sitting up one night at 3 A.M. and give her some advice.

3. All you have to do, I tell her, is switch to Sanka Coffee. Sanka is *real* coffee, delicious coffee—with *97% of the caffein removed.* It lets you sleep in clover. Even doctors recommend it.

4. A few nights later I go back to Min's place for another sales talk. But she must have already switched to Sanka, because she's fast asleep. No wonder I'm Head of the Wisdom Dept.!

SANKA COFFEE

Make Sanka strong—use a heaping tablespoon per cup. If a percolator is used, "perk" Sanka a little longer.

REAL COFFEE . . . 97% CAFFEIN-FREE! DRINK SANKA AND SLEEP!

pass on evidence or the law."

Referring to his part in drawing up practice acts, Mr. Griffin declared that "it was only because the profession would not submit to discipline by the court that the present system had to be proposed. The writer tried several cases before professional boards and learned at first hand the indifference to the rights of the accused . . . The time is now ripe to take the discipline of the licensed professions and vocations out of the hands of their members and transfer it to the courts, with a statutory direction that unethical practice, as well as malpractice, shall be just as punishable by suspension or expulsion as it is in the case of lawyers."

In his rebuttal, Dr. Harris charged that Mr. Griffin had confused the situation by failing to distinguish between ethical transgressions that are not illegal and ethical violations that are.

"The latter are truly for the courts to try," he asserted, "whether committed by professional persons or nonprofessional persons.

"The criminal acts are tried in criminal courts. Ethical violations not involving any legal violations are tried before the offending doctor's fellow physicians and are punished by reprimand, suspension, or loss of membership in a society."

Dr. Harris then pointed out that lawyers are ipso facto officers of the court and responsible to the court for their actions. But, he went on, they may be guilty of some violation of ethics and not necessarily be disbarred, even if dropped by their professional organization.

Dr. Harris, citing the hypothetical case of a consultant who criticizes an attending physician's treatment of a case in front of friends or relatives of the patient, declared:

"Surely Mr. Griffin would not suggest that a reprimand of the unethical consultant by his medical society should be replaced by a court trial and revocation of the consultant's license and deprivation of his means of livelihood!"

Official Hits Red Tape

The head hospital consultant of the War Production Board, Everett W. Jones, has gone on record as opposing compulsory hospital insurance under government management, stating that federal agencies "cannot hope to approach private initiative and enterprise in efficient managment.

"After working fifteen months in Washington," the consultant said,

BEZON FOR EVERY WORKER

—to assure an adequate intake of ***Whole Natural*** Vitamin B Complex.

An increased requirement for Vitamin B Complex has been shown among workers—a need augmented by harder work, longer hours, nervous tension and worry.

BEZON* meets the clinical demand for ***completeness*** in Vitamin B reinforcement.

Because deficiencies seldom occur in one factor of the B Complex only, authorities stress the importance of administering the ***whole*** B Complex.

Certain factors of the B Complex, however, can be obtained only from ***natural*** sources—they cannot be synthesized.

BEZON is ***Whole Natural*** Vitamin B Complex, concentrated to high potency from natural sources—no synthetic vitamin factors are added. Only in the ***Whole Natural*** Vitamin B Complex can ***all*** 22 vitamin B factors be obtained.

BEZON is made only in the distinctive two-color gelatin capsule. Supplied in bottles of 30 and 100 capsules.

Samples and literature available on request

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Whole Natural VITAMIN B COMPLEX

ETHICALLY PROMOTED
—MADE BY THE MAKERS OF BETRON

"I have no delusions left as to the efficiency of governmental agencies. Delay and red tape just can't be eliminated in any political organization as gigantic as our federal government."

Sulfa Chew

A sulfathiazole chewing gum has been announced by White Laboratories, Inc., Newark, N.J. If it is chewed for one half hour, says its sponsor, the gum will assure high and sustained local concentration of sulfathiazole in throat disorders.

Army Uses Serum Albumin

Instead of plasma, a good deal of human serum albumin is being used by the Army in emergency transfusions, according to Dr. John B. Alsever of the United States Public Health Service. Though more expensive, serum albumin saves shipping space, since it comes in vials only one-fourth the size of those used for an equivalent quantity of plasma. Because of army priority, serum albumin is not available for civilian use.

Heart Cases Affect Draft

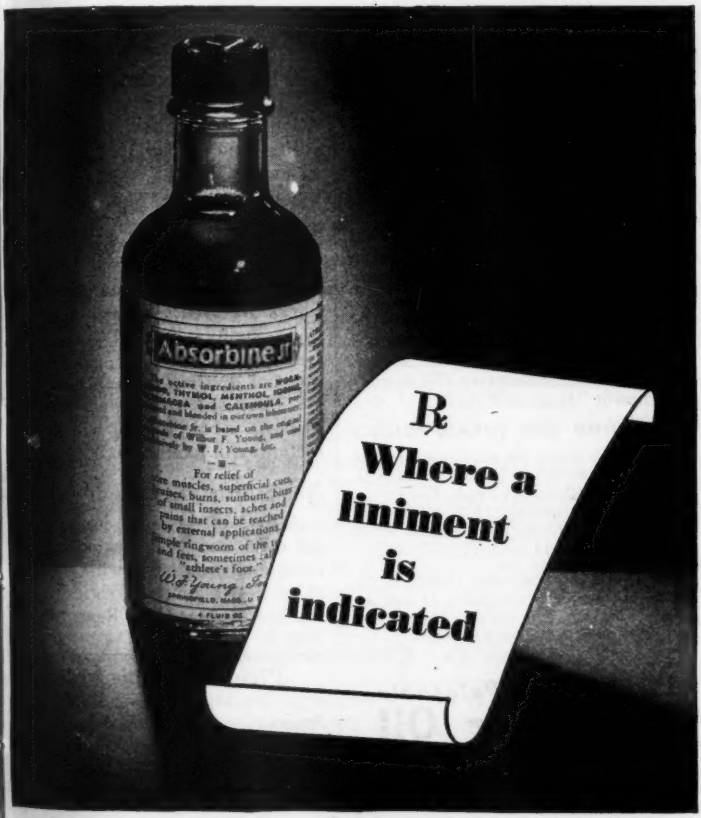
Heart ailments have put 230,000 men in the 4-F draft classification out of 13,000,000 examined, according to Selective Service. It reports that some 115,000 or 50 per cent, suffer from rheumatic fever.

Fliers' Hearing Impaired

Normal hearing will be rare among combat fliers returning from the war, it is predicted by Dr. Walter Hughson of the Abington (Pa.) Memorial Hospital's otological re-

SUGGEST

Absorbine Jr.



search laboratory. Sudden changes in pressure, such as aviators experience in dive-bombing, high-altitude flying, and the constant noise of motors and guns are, he reports, the principal causes.

Field Hospitals Specialized

"Selective hospitalization" has been established by the United States Army in the European theatre to route designated types of casualties directly from the battlefield to hospitals specializing in head and spinal wounds, chest injuries, burns, plastic surgery, and neurosis cases. Col. Edward D. Churchill of Boston, surgical consultant and professor of surgery at Harvard, explained that these hospitals, besides providing quicker and better care for casualties, would serve as educational centers for surgeons.

VDs Drafted and Cured

By inducting men with venereal diseases and curing them, the armed forces are greatly reducing the nation's syphilis problem, says Col. Leonard G. Rowntree, chief of the medical division of Selective Service. He predicts that soon all white men, once rejected for venereal infection, will have been absorbed.

Navy Mortality Reduced

A mortality rate of less than 2½ per cent among all wounded naval personnel, compared with a rate of 7½ to 8 per cent in World War I, has been reported by Rear Admiral Ross T. McIntire.

Pictures in This Issue

Page 50, top, l. to r.: Acme, Press Association, Wide World; bottom: Continental. Page 51, l. to r.: Wide World (2), Acme (2). Page 60: Acme.

THERE's no rule about the length of a war, and no telling how great the sacrifices needed to win it. All we know is that it *must be won.*

We hope and pray that the *next* generation will be spared—that our lads of fourteen and fifteen are not destined for the horrors of war and the fields of battle. We hope that we, of this generation, may transmit to the next generation a world in which ruthless savagery and killing have ceased . . . a world in which they may live and work in peace.

America must not lose this war—*dare* not lose it! We must win as *quickly* and completely as possible. If we win in time, hundreds of thousands of lives will be saved, and the youths of today will build the greater America of tomorrow.

It takes *money* to provide our fighting men with planes, tanks, guns and ships—tens of billions of dollars. It takes *War Bond* money—from you, and you, and you—regularly—10% of your income, at least—more, if you can.

The better we arm our *men,* the more lives of our *boys* will be spared, and the sooner will their future be assured.

Knowing this to be true—knowing that *War Bonds* will help save our country—the lives of our fighting men—yes, even the lives of those who are mere boys now . . .

Can you possibly *not* put every dollar you can scrape together into War Bonds?

Keep on Buying War Bonds

PUBLISHED IN COOPERATION WITH THE DRUG, COSMETIC AND ALLIED INDUSTRIES BY

B-D PRODUCTS

Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

Speaking Frankly

[*Continued from page* 22]

And don't assume that every officer has an orderly to service him. I've often had to make up my own bed and sweep my own room. Not until we reached this "permanent" post were we permitted to hire enlisted men for "striker" service. And that wasn't easy. When a soldier's pay is converted into local currency he is, by the standards here, a rich man—and has little he can spend his money on. So extra cash is no great lure.

We finally made arrangements to have a woman come in and do our housework, and that arrangement has been quite satisfactory. But you can't hire anyone to shine shoes or polish insignia. Each officer does that for himself. In a draft army, where the kitchen helper may be a lawyer and the leaf raker a college instructor, you can't assume that the enlisted man will leap at the chance of doing menial labor for an officer. So while the Army isn't a democracy (you can't decide strategy by debate from the floor), it's a reminder that there is still vitality in the democratic tradition.

Nor are differences in officers' rank at all oppressive. If, at a staff meeting, the lieutenant's therapeutic suggestion is rejected, it's because it isn't workable, not because its sponsor is a one-bar man. I have never met a major or lieutenant colonel who used his rank to force a treatment procedure on an unwilling junior officer. We all know that rank in the Medical Corps cannot faithfully correspond with professional standing, and neither patients nor personnel assumes that a leaf or an eagle confers, in itself, any extraordinary professional acumen.

Promotions do not come as rapidly as our friends back home expect, because the first requirement for promotion is the existence of a vacancy. If your hospital has its quota of majors, no captain can be promoted until a vacancy occurs. Medical officers in line organizations are not so rigidly fixed in grade by the requirements of the organization chart, though length of service, seniority, and existence of vacancies play a part there too.

Backbone of the hospital is the detachment of enlisted men, a group which includes ambulance drivers, typists, mechanics, operating-room

Best results in B Complex therapy are obtained by regular administration *over a considerable period of time.*

Therefore, the physician will wish to prescribe, for his B Complex-deficient patients, a preparation which they will like to take — *and will keep on taking.*

Eskay's Pentaplex—compounded from five important factors* of the Vitamin B Complex *in their crystalline forms* — is just such a preparation. It is outstandingly palatable, pleasing in appearance, and easily tolerated, so that even children and the aged do not tire of it.

ESKAY'S PENTAPLEX

- thiamine hydrochloride
- riboflavin
- niacin
- pyridoxine hydrochloride
- pantothenic acid

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

assistants, cooks, electricians, orderlies, and technicians. We have no trouble with these helpers; there are no strikes for higher wages, no grievance committees, no labor-relations problems. They work at enlisted men's pay, keep soldiers' hours, and turn the wheels that keep the hospital going.

The red tape that fills the nightmares of the raw medical officer is not actually so oppressive. For the most part, paper work is done by officers of the Medical Administrative Corps, thus relieving us of the clerical drudgery about which we complain at home. The part that remains is work the careful doctor will not object to anyway. Most of it is concerned with accurate diagnosis. "Pneumonia," the Army tells you, is not enough—you must indicate whether it's broncho or lobar, right or left, upper lobe or lower, severe or moderate. And it's not whimsy that prompts such requirements, but a passion for scientific accuracy. No medical man worthy of his caduceus can object to that.

Forms, questionnaires, and reports are necessary small stones in the vast structure of public-health work. Out of them the Army—and the medical profession—have learned how to conquer yellow fever, control malaria, reduce mortality from burns, bring down VD rates, and preserve the strength of the fighting man.

We start work at 8 A.M. If we don't want to miss breakfast we have to be in the mess hall at 7:30. Our busy period is from 8 until noon; we make rounds, administer or supervise treatment, answer consultations, perform operations. In the afternoon, unless a large number of patients have come in, we manage a siesta to escape the oppressive heat of the sun. Evening mess is early—5 o'clock, or 1700 hours as we say in our best jargon. Evenings, one man takes over for night rounds, handles emergencies, and responds to calls from the wards. Some of us visit the local movie house; but most sit in the officers' "club" and gossip, discussing the sulfa drugs, the girls back home, or what we'd tell Generals Eisenhower and MacArthur if they asked us for advice. Officers off duty may go out for a swim or a glass of beer; if not they can usually find a bridge or cribbage game somewhere.

And so to bed—usually by 2230 hours (you figure it out). "Bed" is generally a folding cot with a deep

announcing

A NEW TECHNIQUE OF LOCAL CHEMOTHERAPY IN ORAL AND PHARYNGEAL INFECTIONS

Recent reports* indicate the clinical value of the sulfonamide compounds as topical medication in oral and pharyngeal infections.

For such conditions White's Sulfathiazole Gum now provides a more effective, prolonged, convenient and pleasant method of local chemotherapy than short-acting gargles, sprays and dusting powders.

Dosage

One (or two) tablets of White's Sulfathiazole Gum, chewed for one-half to one hour at intervals of one to four hours. Each tablet, containing 3.75 grs. (0.25 Gm.) Sulfathiazole, initiates and maintains an average of 70 mgm. per 100 cc. of saliva throughout the chewing period.

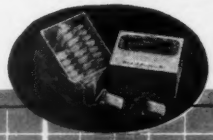
Indications

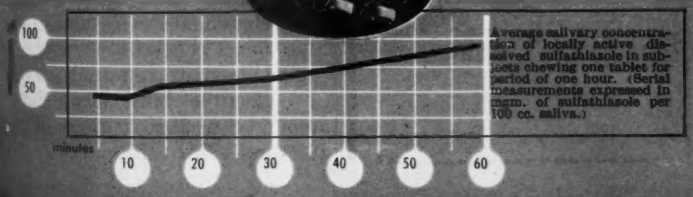
In the *local* treatment of acute and chronic sulfonamide-susceptible infections of oral and pharyngeal mucosa and contiguous tissues; e.g., tonsillitis, pharyngitis, infections, gingivitis and stomatitis, non-epidemic parotitis, peritonsillar abscess; also as prophylaxis in the post-tonsillectomy state.

Supplied in packages of 24 tablets on prescription only. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

*Literature on request

White's sulfathiazole gum





gully down its axis—the imprint of a body molded into sagging canvas. We have learned when crawling into it how to slip under the mosquito netting without letting in any of the insects.

Grousing, they say, is a sign of good morale. So we grouse about flies, mosquitoes, and termites; and about the drenching rain and sweltering sun. We can all tell you what's wrong with the Army. But would we have wanted to miss the experience? Tell it to the marines!

Henry A. Davidson
Captain, M.C.
Somewhere in the Pacific

Doctors' Income

[*Continued from page* 43]

quested to estimate the amount of 1941 gross income "which was received from insurance companies, corporations, other business enterprises, or social welfare agencies (as contrasted with fees paid by patients or their relatives and friends.)"

Answers showed that 8.8 per cent of 1941 gross receipts from independent practice ($750 per doctor) was derived from these sources, while 91.2 per cent of gross receipts ($7,724 per doctor) resulted from individual consumer payments. About 27 per cent of independent physicians received more than $1,000 a year for professional services rendered to business concerns.

The median reported value of collectible bills outstanding amounted to $843 at the end of 1939 and $875 at the end of 1941.